Maternal and Child Health Services Title V Block Grant

Hawaii

Created on 7/15/2019 at 7:31 PM

FY 2020 Application/ FY 2018 Annual Report

Table of Contents

I. General Requirements 4

I.A. Letter of Transmittal 4

I.B. Face Sheet 5

I.C. Assurances and Certifications 5

I.D. Table of Contents 5

II. Logic Model 5

III. Components of the Application/Annual Report 6

III.A. Executive Summary 6

III.A.1. Program Overview 6

III.A.2. How Federal Title V Funds Support State MCH Efforts 11

III.A.3. MCH Success Story 11

III.B. Overview of the State 13

III.C. Needs Assessment 24

FY 2020 Application/FY 2018 Annual Report Update 24

FY 2019 Application/FY 2017 Annual Report Update 28

FY 2018 Application/FY 2016 Annual Report Update 33

FY 2017 Application/FY 2015 Annual Report Update 37

Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report) 41

III.D. Financial Narrative 63

III.D.1. Expenditures 65

III.D.2. Budget 73

III.E. Five-Year State Action Plan 78

III.E.1. Five-Year State Action Plan Table 78

III.E.2. State Action Plan Narrative Overview 79

III.E.2.a. State Title V Program Purpose and Design 79

III.E.2.b. Supportive Administrative Systems and Processes 81

III.E.2.b.i. MCH Workforce Development 81

III.E.2.b.ii. Family Partnership 84

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts 87

III.E.2.b.iv. Health Care Delivery System 89

III.E.2.c State Action Plan Narrative by Domain 91

Women/Maternal Health 91

Perinatal/Infant Health 104

Child Health 127
Adolescent Health 152
Children with Special Health Care Needs 165
Cross-Cutting/Systems Building 179
III.F. Public Input 185
III.G. Technical Assistance 190
IV. Title V-Medicaid IAA/MOU **191**
V. Supporting Documents **192**
VI. Organizational Chart **193**
VII. Appendix **194**
Form 2 MCH Budget/Expenditure Details 195
Form 3a Budget and Expenditure Details by Types of Individuals Served 203
Form 3b Budget and Expenditure Details by Types of Services 205
Form 4 Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated 208
Form 5 Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V 211
Form 6 Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX 215
Form 7 State MCH Toll-Free Telephone Line and Other Appropriate Methods Data 218
Form 8 State MCH and CSHCN Directors Contact Information 220
Form 9 List of MCH Priority Needs 223
Form 9 State Priorities-Needs Assessment Year - Application Year 2016 224
Form 10 National Outcome Measures (NOMs) 226
Form 10 National Performance Measures (NPMs) 265
Form 10 State Performance Measures (SPMs) 275
Form 10 Evidence-Based or –Informed Strategy Measures (ESMs) 278
Form 10 State Performance Measure (SPM) Detail Sheets 291
Form 10 State Outcome Measure (SOM) Detail Sheets 293
Form 10 Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets 294
Form 11 Other State Data 308

I. General Requirements

I.A. Letter of Transmittal

DAVID Y. IGE
GOVERNOR OF HAWAII

BRUCE S. ANDERSON, Ph.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:
File:

July 12, 2019

Michael D. Warren, M.D., M.P.H., FAAP
Associate Administrator
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, 18W
Rockville, Maryland 20857

Dear Dr. Warren:

The State of Hawaii wishes to formally apply to the Maternal and Child Health Bureau for continued funding under the Maternal and Child Health Services, Title V Block Grant Program for fiscal year (FY) 2020 (October 1, 2019 – September 30, 2020). The FY 2020 application and FY 2018 annual report is submitted via the Health Resources and Services Administration Electronic Handbooks (EHBs).

Please note that the Title V grant proposal guidance states that a signed copy of the application face sheet, Standard Form 424, is no longer required. Therefore, this document will also be submitted electronically through the EHBs.

If you have any questions, please contact Annette Mente at (808) 733-8358 or email at annette.mente@doh.hawaii.gov.

Sincerely,

Bruce S. Anderson, Ph.D.
Director of Health

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Hawaii is the only island state in the U.S. and is comprised of seven populated islands organized into four major counties: Hawaii, Maui, Honolulu (Oahu), and Kauai. Spanning nearly 11,000 square miles (with a land mass of 6,422 square miles), the state is home to 1.4 million residents with 70% living in Honolulu, the most populous county.

Hawaii is also one of the most ethnically diverse states, with no single majority race (38% Asian, 25% White, 10% Native Hawaiian/Pacific Islander, 2% Black). In addition, nearly 23% of the population is mixed race. Indigenous Native Hawaiians comprise roughly 6.1% of the population.

The state government is responsible for functions usually performed by counties or cities in other states. Hawaii is the only state, for example, with a single unified public-school system. Similarly, Hawaii has no local health departments, but has county health offices on the 'neighbor islands' to assure services statewide.

The Hawaii State Department of Health (DOH) works to protect and improve the health and environment for all people in the State. Because DOH is the only public health agency in the state, programs are key in providing statewide leadership for critical public health surveillance, planning, and prevention functions.

Recognizing the importance of establishing a foundation of health early in life, one of the three DOH strategic goals is investing in healthy babies, mothers, and families. The DOH Family Health Services Division (FHSD) utilizes the federal Title V Maternal and Child Health Block Grant (Title V) to address this goal and fulfill its commitment to improve the health of women, infants, and children, including those with special health care needs. In addition, FHSD works to address social determinants of health and improve health equity, utilizing multi-generational approaches.

Hawaii Title V MCH Priorities

The Hawaii State Title V Plan for 2016-2020 includes eight national priorities based on the 2015 needs assessment. Together, the priorities address the five population domains served by FHSD, as well as the cross-cutting systems-building domain. The domains and priorities are listed in the table below.

Domain	State Priority Need
Women's/Maternal Health	Promote reproductive life planning.
Perinatal/Infant Health	Reduce the rate of infant mortality by improving breastfeeding rates.
	Reduce the rate of infant mortality by promoting safe sleep practices.
Child Health	Improve the percentage of children age 0-5 years screened early and continuously for developmental delay.
	Improve the oral health of children.
	Reduce the rate of child abuse and neglect, with special attention on ages 0-5 years.
Adolescent Health	Improve the healthy development, health, safety, and well-being of adolescents.
Children with Special Health Care Needs	Improve the percentage of youth with special health care needs ages 12-21 years who receive services necessary to make transitions to adult health care.
Systems Building	Improve access to services through telehealth.

Title V National & State Performance Measures (2018)

The Hawaii national performance measures (NPMs) are:

- NPM 1: Well-woman visit
- NPM 4: Breastfeeding
- NPM 5: Safe sleep
- NPM 6: Developmental screening
- NPM 10: Adolescent well visits
- NPM 12: Transition to adult care
- NPM 13.2: Children's oral health

The current Hawaii state performance measures (SPMs) are:

- SPM 1: Telehealth
- SPM 4: Child abuse & neglect

The key accomplishments for FY 2018 and plans for FY 2020 are summarized below.

DOMAIN: WOMEN'S/MATERNAL HEALTH

Promote reproductive life planning

Accomplishments: Title V is a key partner in the Hawaii Maternal and Infant Health Collaborative (HMIHC), which continues to promote use of the One Key Question® (OKQ®) screening approach and Long Acting Reversible Contraception (LARC), both evidence-based/informed strategies adopted from the MCH Bureau Infant Morality CoIIN. A certification course offered by the University of Hawaii-Hilo allows pharmacists to prescribe and dispense contraceptive supplies, increasing women's access to LARC supplies. The HMIHC continues to clarify LARC insurance reimbursement policies and address claims processing issues experienced by Medicaid providers.

Challenges: Acquiring timely data to monitor project benchmarks and complete evaluation has been challenging. Private insurance and claims reimbursement barriers also remain for LARC insertion.

Plans: FHSD will continue OKQ training targeting primary care providers, reduce barriers to OKQ training by creating a web-based training, complete evaluation of OKQ screening at pilot sites, and address barriers to Medicaid LARC reimbursements. The HMIHC will also focus on public awareness and messaging to promote healthy behaviors including preventive women's health visits and reproductive life planning.

DOMAIN: PERINATAL/INFANT HEALTH

Promote breastfeeding

Accomplishments: A statewide meeting of stakeholders was held to prioritize the tasks for implementation of the breastfeeding strategic plan. The HMIHC breastfeeding work group began project implementation including identified of priorities and resources to support progress. WIC Services Branch staff help to convene the work group. WIC also continued its successful Breastfeeding Peer Counselor Project.

Challenges: Securing additional support/resources for implementation of the state breastfeeding plan has been ongoing. Work also continues with birthing facilities to improve breastfeeding policies, hospital discharge planning support, and assessment of staff competency.

Plans: Three priority projects from the state breastfeeding plan will be implemented: conduct training on insurance reimbursement for lactation support providers who are not primary care providers, offer an indigenous breastfeeding course to service providers, and expand the Breastfeeding Peer Counselor Project to Hawaii Island.

Promote safe sleep practices
Accomplishments: All Hawaii birthing hospitals adopted safe sleep protocols aligned with the American Academy of Pediatrics' recommendations. Findings from the review process also identified workforce training needs and resources, as well as collected information helpful in developing Safe Sleep messaging for parents and families. The Title V Safe Sleep program partners with the state Department of Human (DHS) Child Care program to provide safe sleep training and information for all licensed childcare providers and the families they serve.

Challenges: The practice of co-sleeping among local families may be related to ethnic/cultural norms, and also small or multi-family living arrangements due to high housing costs. Thus, safe sleep education/outreach must be culturally appropriate/relevant for Hawaii's diverse populations and communities.

Plans: To expand outreach, DOH, DHS, and the state Office of Language Access (OLA) will translate Safe Sleep educational materials for families into 11 of Hawaii's most common non-English languages. FHSD will also continue ongoing work including utilizing data (including Child Death Review findings) to guide interventions, Pack 'n' Play distribution and program evaluation, and Safe Sleep Hawaii coalition activities.

DOMAIN: CHILD HEALTH
Improve early and continuous screening for developmental delay
Accomplishments: Guidelines on developmental screening, referral, and services were completed with stakeholder input and disseminated to the state early childhood (EC) community. Partnerships continued with state EC organizations to promote a system of developmental screening and referral. FHSD's Early Childhood Comprehensive Systems grant contracted with the University of Hawaii to create a data system to capture the number of children screened, referred, and receiving services on Maui. Data were analyzed to monitor and improve screening and referral activities among programs.

Challenges: The need remains for an integrated developmental screening system to ensure there are supports available statewide and in each community to identify children who may have a concern and require follow-up support and services. This includes infrastructure support such as training and designing data systems.

Plans: Continue work with partners from early childhood and health care sectors, to ensure a system can be developed so children are not being over-screened, and when identified, receive access to appropriate supports and services.

Improve the oral health of children
Accomplishments: The State Oral Health Program (SOHP) completed work on the five-year CDC oral health grant. This included the Head Start/Early Head Start oral health screening survey, collection of community input (e.g., through townhall meetings and stakeholder surveys), a state conference to collect input for the state oral health plan, and sustainment of the State Oral Health Coalition. The pilot Virtual Dental Home teledentistry project demonstrated the program is a sustainable and cost-effective service model with Medicaid reimbursement.

Challenges: Maintaining adequate and sustainable funding for the SOHP remains a challenge. Securing legislative support to reinstate Medicaid adult dental benefits also remains a priority.

Plans: Upcoming activities include: dissemination of the Head Start/Early Head Start survey report and the state oral health community plan; continued coalition-building for policy development, planning, and coordination; continuation of the Virtual Dental Home teledentistry project; and exploration of options to fund the SOHP.

Reduce the rate of child abuse and neglect (CAN)
Accomplishments: The Early Childhood Action Strategies partnership developed a five-year communication plan to increase awareness about family violence and promote safe/healthy family relationships. Also, the Title V CAN Prevention program joined a new partnership with the state Child Welfare Services program and the Hawaii Judiciary to develop the next five-year Child and Family Service Plan (CFSP). The plan has a focus on preventing children from entering the foster care system. The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program continues to provide evidence-based services to at-risk families.

Challenges: Key challenges include promoting greater collaboration across the service system to strengthen the impact and sustainability of prevention programs, and identifying effective/affordable evaluation measures for population-based prevention activities/campaigns.

Plans: Work to develop a statewide CAN surveillance system has begun, in collaboration with community

stakeholders. Title V violence prevention programs will continue to conduct workforce training events on toxic stress, resiliency, and trauma-informed care. The five-year CFSP will be completed. The family violence communications plan will be implemented with a messaging campaign.

DOMAIN: ADOLESCENT HEALTH

Improve adolescent health and well-being

Accomplishments: Title V is designing an Adolescent Resource Toolkit (ART) to provide health information (including the importance of wellness visits) to adolescents and youth service providers. The ART was revised based on input from teens in the Personal Responsibility and Education Program, as well as community service providers. Workforce training efforts on healthy youth development targeted providers working with at-risk youth in youth detention and correctional settings, helping to ensure physical assessments are provided upon entry to these facilities.

Challenges: Ongoing efforts are being made to engage more adults and service providers to help adolescents understand the importance of an annual wellness visit and encourage teens to independently seek care.

Plans: Training of community health workers in rural areas will begin, so these providers may utilize the ART with adolescents to provide health information, conduct simple assessments, promote the importance of wellness visits, and link teens to services. The program will also continue to collect input from adolescents and providers on the ART to assure its effectiveness.

DOMAIN: CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

Improve transitions to adult health care

Accomplishments: The Children and Youth with Special Health Needs Section (CYSHNS) improved transition planning services for enrolled youth using the evidence-based Six Core Elements of Health Care Transition. The CYSHNS data system upgrade is nearly completed, allowing for tracking of client transition plans. Education and public awareness efforts continued through transition fairs, conferences, and other events, in collaboration with state and community partners. A draft of CYSHNS's outreach and assessment materials will be reviewed by youth and consumers.

Challenges: Establishing partnerships with adult health care agencies and providers to promote transition planning is a challenge given shortages of adult health care providers, especially for CSHCN. Developing methods to measure the effectiveness of education/outreach activities is also an ongoing process.

Plans: Development of education and assessment materials will be completed, as well as the data monitoring system. Education and public awareness on transition to adult health care will continue. CYSHNS will also partner with the Title V Adolescent Health Program to increase outreach to all adolescents, with and without special health care needs.

DOMAIN: CROSS-CUTTING/SYSTEMS BUILDING

Promote telehealth

Accomplishments: FHSD continues to increase telehealth activities for workforce training, as well as for direct services to the community (e.g., genetics, newborn screening, early intervention, WIC services, and MIECHV activities). Project ECHO Hawaii continues to use videoconferencing to build health care workforce capacity while improving patient access to specialty health care in rural communities. FHSD staff are also using videoconferencing daily for communication among DOH programs and community partners.

Challenges: It is an ongoing process for programs/staff to learn and apply new skills and technology tools for services, education, and meetings.

Plans: Work will continue with community partners to develop infrastructure for telehealth, including policies/procedures and a network of telehealth sites and personnel. Workforce development and training on and with telehealth will continue with FHSD staff, as well as through other identified opportunities. Finally, the program will continue to identify services that may be provided using telehealth, pilot such innovative programs, and expand successful pilot programs.

Five Year Needs Assessment

The Title V needs assessment plan is completed, and implementation has begun in FY 2019 including both primary and secondary data collection with technical assistance from the University of Hawaii's Office of Public Health Studies. FHSD has formed a needs assessment collaborative to utilize resources from several FHSD programs including Title V, MIECHV, CAN Prevention, the Primary Care Office, and state Early Childhood/Preschool

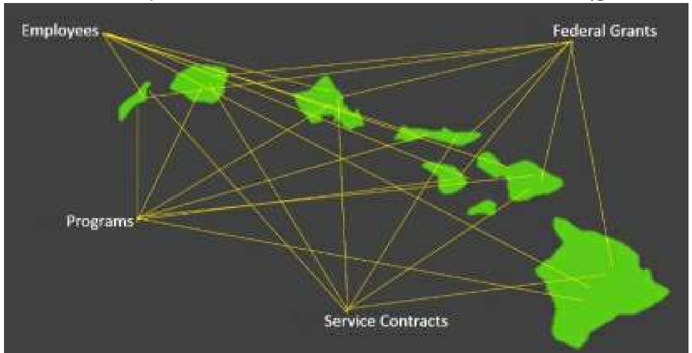
Development Grant. New five-year priorities will be identified by October 2019 and plan strategies, activities, and strategy measures will be selected by May 2020.

MCH Workforce Development
FHSD staff totaled 337.5 FTE in FY 2018, and represent diverse training backgrounds and program experience in varied fields and subject areas. Many have topic-specific knowledge and program management expertise, but may not have formal training in foundational public health skills needed to assess and align community data, system resources, and prevention strategies to improve Title V national performance measures. Technical assistance, secure through the federal State Systems Development Initiative grant, is used to assist staff with developing the Title V report/application to build FHSD's public health capacity.

III.A.2. How Federal Title V Funds Support State MCH Efforts

FHSD provides all levels of service delivery: direct, enabling, and infrastructure building. One of the largest Divisions in DOH, FHSD is has 3 branches – Maternal and Child Health (MCH), Children with Special Health Needs (CSHN), and Women, Infants and Children (WIC) Services. Together, the Division administers 30 programs, 18 federal grants, approximately 150 service contracts with community-based organizations totaling roughly $50M, all with 337.5 FTE (FY2018) positions statewide.

In 2018 the FHSD budget was $96.9 M. Nearly $2M was provided by Title V, with $44.9M state matching funds, and an additional $50M in other federal funds. Of the state's overall population, FHSD programs reached an estimated 46% of pregnant women, 100% of all infants, 12% of children 1-21 years of age, 15% of children with special health needs, and 3% of others (general adult population).



To support the infrastructure needed to administer MCH programs statewide, Title V funds are used for key staff positions (21.15 FTE) including epidemiologists, research statisticians, MCH and CSHN program managers, a part-time Pediatric Medical director, nurses, a nutritionist, an audiologist, and contract manager. These positions are critical to: 1) securing, leveraging, and managing a broad array of funding sources; 2) addressing statewide surveillance needs; 3) developing critical statewide partnerships; and 4) improving quality to assure services are family-centered, culturally relevant, and community based.

III.A.3. MCH Success Story

A Success Story

Darren has received Children with Special Health Needs Program (CSHNP) services since he was an infant diagnosed with a metabolic disorder. His condition has severe health problems if not treated. A pediatric nutritionist adjusted his intake of medical foods based on lab tests. She also provided guidance on protein intake, activities, and emotional support. She worked with a pediatric metabolic specialist, whose services were supported in part by the Genetics Program.

His services were coordinated among his health care providers. The nutritionist helped when it was hard for the family to get metabolic foods from pharmacies. As he grew, they talked about selecting a job that considered his metabolic condition.

Darren is now married and has a 3-year-old child. He works full-time as a pharmacy technician at a hospital. He continues to attend CSHNP Saturday gatherings for children and youth with metabolic conditions and encourages others in moving forward (it can be done!).

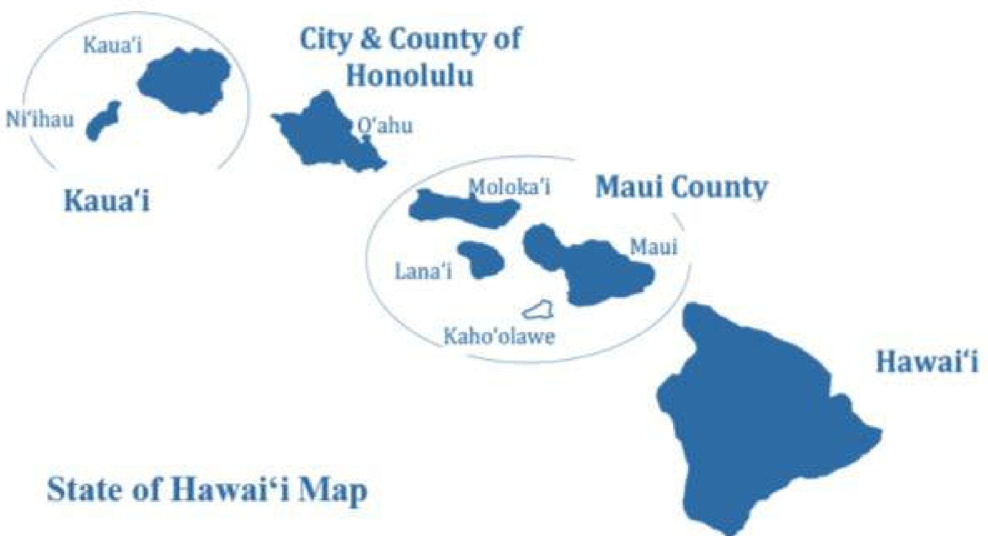
As a young man, Darren is now transferring to an adult health provider. He is aware about health insurance coverage and benefits. His new doctor has been informed about Darren's metabolic condition.

The federal-state Title V partnership has contributed to improving the health and development of children and youth with special health care needs. Hawaii DOH partners include Newborn Screening, Early Intervention, Children with Special Health Needs, Genetics, and Birth Defects Programs.

III.B. Overview of the State

GEOGRAPHY

Hawaii is situated almost in the center of the Pacific Ocean and is one of the most isolated yet populous places on Earth. The west coast of North America is 2,400 miles from Honolulu, roughly a 5-hour flight by air. Five time zones separate Hawaii from the eastern U.S. This means 9 am in Washington, D.C. is 6 am in Los Angeles and 3 am in Hawaii. Nationally, Hawaii is the 11th smallest state by population size and 4th smallest by land area.



The State is composed of 7 populated islands in 4 major counties: Hawaii, Maui, Oahu, and Kauai. The county is the lowest civil subdivision in the state. As a result, counties in Hawaii provide some services, such as fire and police protection, that in other states are performed by cities or towns. Counties also elect a mayor and council. Likewise, the state government is responsible for functions usually performed by counties or cities in other states. Hawaii is the only state, for example, with a single unified public school system. Similarly, Hawaii has no local health departments, but district health offices for each of the three neighbor island counties.

Approximately 70% of the state population resides in the City and County of Honolulu on the island of Oahu, concentrated in the Honolulu metropolitan area. The neighbor island counties are Hawaii, Kauai (includes Niihau which is privately owned with restricted access) and Maui (includes Molokai, Lanai, and Kahoolawe-which is unpopulated).

Only 10% of the state's total land area is classified as urban. The City and County of Honolulu is the most urbanized with a third of its land area and 96% of its population in urban communities. Most tertiary health care facilities, specialty and subspecialty services, healthcare providers are located on Oahu. Consequently, neighbor island and rural Oahu residents often travel to Honolulu for these services. Interisland passenger travel is entirely by air. Air flights are frequent, but comparatively expensive. Airfare costs can be quite volatile based on varying fuel costs. This creates a financial barrier for neighbor island residents since round-trip airfare costs range from $130 to over $200.

Geographic access is further limited because public transportation is inadequate in many areas of the state except for the Honolulu metropolitan area. Over the past five years, the islands of Maui, Kauai, and Hawaii have established limited public bus service, but their use by residents is largely sporadic. Residents in rural communities, especially on the neighbor islands, rely on automobiles to travel to major population centers on their island where health care services are available including primary care, hospital, specialty, and subspecialty services. Because of the

mountainous nature of the islands, road networks are sparse and, in some places, limited to a single highway near the coast. Access to emergency care on neighbor islands often requires the use of helicopters or fixed-wing aircraft.

DEMOGRAPHICS

The estimated 2018 state population is 1,420,491 residents, the 30th most populous state in the U.S. Oahu (980,080 residents) is home of 69.0% of the state's population, while 14.1% live on the Big Island (200,983 residents), 11.8% (167,207 residents) in Maui County, and 5.1% (72,133 residents) in Kauai County. From 2010 to 2018, the U.S. Census Bureau estimated an overall growth in the state of 4.4%: 7.5% in the county of Kauai, 8.0% in the county of Maui, 8.6% in the county of Hawaii, and 2.8% in the city and county of Honolulu.

ETHNIC DIVERSITY

Hawaii is one of the most ethnically diverse states in the U.S. with no single race majority. According to the 2017 American Community Survey (ACS), 23.3% of the population reported two or more races, and the following single race proportions (White=25.0%, Asian=38.2%, Native Hawaiian or Other Pacific Islander (NHOPI)=10.2%. The largest Asian single race sub-groups were Filipino (15.6%), and Japanese (11.8%) and the largest NHOPI single race sub-group was Native Hawaiian (6.1%). The individual Asian and NHOPI sub groups are listed in the table below and show the heterogeneity of these aggregated Race groupings.

Race Group		Detailed Sub Groups
Asian		Filipino Japanese Chinese Korean Vietnamese Asian Indian Thai Laotian Taiwanese Cambodian Indonesian
Native Hawaiian or Other Pacific Islander	Polynesian	Native Hawaiian Samoan Tongan
		Tokelauan
		Tahitian
	Micronesian	Guamanian or Chamorro Marshallese Kosraean Chuukese Palauan
		Yapese
		Saipanese
		I-Kiribati
	Melanesian	Fijian
		Papua New Guinean
		Ni-Vanuatu
		Solomon Islander

Sources: US Census Bureau. The Asian Population: 2010. 2010 Census Briefs. Issued March 2012; C2010BR-11.

US Census Bureau. The Native Hawaiian and Other Pacific Islander Population: 2010. 2010 Census Briefs. Issued May 2012; C2010BR-12.

Table: Asian and Native Hawaiian or Other Pacific Islander Race Groupings Detail, 2010 Census.

	Resident Population in the State of Hawaii (N)	Percent of State Population (%)	Proportion Reporting at least one other Race (%)
White Alone	357,113	25.0%	0
White Alone or in Combination	613,156	43.0%	41.7%
Native Hawaiian or Other Pacific Islander (NHOPI) Alone	145,271	10.2%	0
NHOPI Alone or in Combination	366,803	25.7%	60.5%
Native Hawaiian Alone	*87,020*	*6.1%*	*0*
Native Hawaiian Alone or in Combination	*302,339*	*21.2%*	*71.2%*
Asian Alone	545,639	38.2%	0
Asian Alone or in Combination	797,617	55.9%	31.6%
Filipino Alone	*222,620*	*15.6%*	*0*
Filipino Alone or in Combination	*367,364*	*25.7%*	*39.4%*
Japanese Alone	*169,003*	*11.8%*	*0*
Japanese Alone or in Combination	*299,035*	*20.9%*	*43.5%*
Chinese Alone	*79,078*	*5.5%*	*0*
Chinese Alone or in Combination	*196,223*	*13.7%*	*59.7%*

Source: U.S. Census Bureau. 2017 American Community Survey Calculations by Hawaii Department of Health, Family Health Services Division.
Note: The U.S. Census Bureau adheres to the 1997 Office of Management and Budget (OMB) standards on race and ethnicity in classifying written responses to the race question. Respondents are given the option of reporting more than one race. Therefore, two basic ways of defining a race group are possible. A group such as White may be defined as those who reported White and no other race (the race-alone or single-race concept), or as those who reported White regardless of whether they also reported another race (the race-alone-or-in-combination concept). The "Alone or in Combination" proportions will not sum to 100% due to a resident belonging to more than one of the five federal race groups (White, Black, Asian, NHOPI, American Indian/Alaskan Native).

Table: Total Numbers within Selected Race Groupings by Alone and Alone or in Combination status, Percent of State Population, and Percent Reporting at least one other race, Hawaii, 2017 American Community Survey

Those that report two or more race groups are not included in the single race groups commonly reported. Due to the large proportion with more than one race, recommendations are to report race as "alone" or "alone or in combination" with another group. For example, Native Hawaiian accounted for 21.2% of the state population when reported as "alone or in combination," compared to just 6.1% when Native Hawaiian is reported singly. There is also variation among race sub groups an overall estimate of 31.6% of those in the Asian Alone or in combination reporting another race but variation in the 3 largest sub groups range from 39.4% in Filipino to 59.7% in Chinese. The other Asian sub groups are likely newer immigrants to Hawaii compared to these three and have smaller numbers reporting more than one race group.

Given the state's unique characteristics, particularly the diversity in ethnicity, language and cultural practices, many best practices may not translate well to Hawaii.

Immigration

Hawaii is considered a gateway to the U.S. for immigrants from Asia and the Pacific. According to the 2017 ACS, 18.6% of Hawaii's population is foreign-born, the 6th highest percentage in the U.S. Nearly 39,000 immigrants

were legally admitted to the state between 2003 and 2013, mainly from the Philippines, Japan, Korea and Vietnam. Smaller groups of Hispanic immigrants have settled in parts of Maui and Hawaii Islands, attracted by jobs in tourism and agriculture. Estimates of illegal immigrants in Hawaii range from six to nine thousand.

Languages Spoken

Because of Hawaii's ethnic diversity, limited English proficiency poses challenges for educational achievement, employment, and accessing services, and may impact the quality of care for immigrant communities. Based on 2013-2017 ACS, an estimated 25.8% Hawaii resident ages 5 years and over spoke a language other than English at home, compared to 21.3% nationally. An estimated 12.4% of Hawaii residents reported limited English proficiency (4th highest state ranking), compared to 8.5% nationally. Based on the 2009-2013 ACS 5-year estimates, the most common languages spoken at home other than English include Other Pacific Island languages (81,555), Tagalog (58,345), Japanese (45,633), and Spanish (25,490), followed by Chinese (17,360), Korean (17,276) and Vietnamese (9,418).[1]

In School Year 2015-2016 (latest available data), 8.3% (13,619) of the state's public school students were enrolled in English Language Learner Program.[2] The top five languages spoken by Hawaii public school students are Ilokano, Chuukese, Marshallese, Tagalog, and Spanish.

Compact of Free Association (COFA)

In Hawaii, there is a growing concern over the impact of COFA migrants that includes Federated States of Micronesia, Republic of Marshall Islands, and Republic of Palau. Under the compact, COFA migrants are designated as legally residing noncitizen nationals who can freely live and work in the U.S. This status was negotiated in exchange for allowing the U.S. military to control strategic land and water areas in the region. Prior to 1996, COFA migrants qualified for federal benefits such as Medicaid, Social Security, disability, and housing programs. The passage of the 1996 Welfare Reform Act removed their eligibility to these entitlement programs with the state assuming most of the costs for services.

There are reports of high rates of morbidity due to chronic disease (diabetes, obesity, smoking), reports of communicable diseases (tuberculosis, Hansen's disease/leprosy), and other medical concerns (which may be related to U.S. nuclear tests conducted in the Pacific nations) with additional challenges due to substantial language and cultural barriers within the COFA population. In 2017, the social, health, educational, and welfare system costs attributed to the estimated 14,700 COFA migrants in Hawaii was $147.3 million dollars. Estimates indicate roughly 1,000 migrants are homeless. Migrants account for about 2-3% (400-600) births annually in Hawaii, with low rates of prenatal care utilization, high rates of low birth weight, and recent concerns about high rates of NICU admissions.[3]

In 2018, the Title V agency served an estimated 6,485 COFA migrants at a cost of $2.8M. Programs reporting COFA clients served included WIC, State-funded Primary Care program (for uninsured/underinsured), Hawaii's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, Family Planning, Perinatal Support Services, and Early Intervention Services.

Military

Other sub-populations within the state include U.S. Armed Forces personnel and their dependents which, in 2017, comprise an estimated 7.4% of the state's population (105,272 people).[4] There are several major military health facilities to serve this population located on Oahu. The Tripler Army Medical Center is the only federal tertiary care hospital in the Pacific Basin. It supports 264,000 local active duty and retired military personnel, their families, and veteran beneficiaries. Medical services are also available on military bases through several clinics for active duty members and their dependents.

Homelessness

Hawaii's 2018 Point-in-Time homeless study estimates the total number of homeless individuals statewide at 6,530. The proportion of unsheltered individuals (53.2%) was higher than sheltered individuals (46.8%). The trend of homeless has declined from 7,220 in 2017. About 36.7% (2,399) of the homeless were part of families, including 16.2% (1,060) children under age 18 years living sheltered, and 295 children living unsheltered.[5]

Maternal and Child Population

The 2017 estimates show that there were 265,924 women of reproductive age (15-44 years old) a 1.4% increase from 2010, representing 18.6% of the entire state population.

During the last 24 years, the number of births in Hawaii varied from about 17,000 to 20,500 annually. There was a steady increase in the number of births since the late 1990's with about 18,000 births every year in the state over the past 5 years.

The 2017 population estimates show that there were 176,901 children 9 years of age or younger in Hawaii, which represents a 3.6% increase from 2010. This group represents 12.4% of the state population. There were 159,029 children 10-19 years of age in Hawaii, which represents a 5.1% decrease from 2010. This group represents 11.1% of the state population.

Based on the 2017 National Survey of Children with Special Health Care Needs (CSHCN), there are an estimated 40,367 CSHCN, representing 14.5% of all children ages 0-17 years old.

Older Population

Hawaii's population, like the U.S., is aging. Based on 2017 population estimates, persons age 65 years and over comprised 17.8% of the population, compared to 14.3% in 2010. Nationwide, this population comprised 15.6% in 2017 compared to 13.0% in 2010.

ECONOMY

Hawaii's economy is largely driven by tourism, real estate, construction sectors, and military spending. Like the rest of the U.S., the Hawaii economy has improved since the 2009 recession.

Economic Growth

The Hawaii State Department of Business, Economic Development and Tourism (DBEDT) first quarter 2019 outlook shows slower but stable growth for Hawaii's economy, with the final growth rate for 2018 at 1% and forecasted growth for 2019 at 1.2%. This outlook is based on the most recent developments in the performance of Hawaii's tourism industry, low unemployment rate, labor market conditions, and the growth of non-agriculture payroll jobs and healthcare industries.[6] The state real gross domestic product (GDP) grew 2.0% in 2018, and is expected to grow by 2.3% in 2019 and in 2020. The per capita real GDP in Hawaii was $55,668 in 2017 (in 2012 dollars), $250 or 0.5% higher than the U.S. average.[7] Hawaii ranked 18th among the 50 states.

Unemployment

Hawaii unemployment rates reflect the state's economic recovery. The state's unemployment rate peaked at 7.4% after the 2009 recession with a record 47,000 individuals unemployed. According to the Bureau of Labor Statistics, the annual average unemployment rate in Hawaii was 2.4% in 2018, 1.5% points lower than the U.S. average of 3.9%.[8] Hawaii ranked the lowest among the 50 states.

State Budget

According to the Hawaii Department of Taxation, the State Council on Revenues lowered its forecast for growth in the State General Fund tax revenue in FY 2019 from 4.2% to 3.0%.[9] The Council also maintained its annual growth forecast for FY 2020 to FY 2025 at 4.0%. The Council noted that the decision to lower the estimate was based on the expectation of lower economic growth and lower than expected tax revenue growth. The Council also discussed the temporary effects of the tax law changes of Tax Cuts and Jobs Act passed in December 2017, which may have caused a one-time increase in state tax payments in the prior fiscal year.

Tourism

2018 was another record-breaking year for tourism with 10.0 million travelers coming to the islands and visitor expenditures of $17.8 billion. Although vulnerable to changing markets and trends, in 2019, forecasters expect visitor arrivals and visitor expenditures will continue to increase.

Poverty

Based on 2017 estimates, Hawaii's poverty rate was 9.5% (all ages in poverty), lower than the U.S. rate of 13.4%. This represents an estimated 132,549 individuals living in poverty in the state; over 34,441 or 11.5% of those under 18 years of age live in households below the Federal Poverty Level (FPL). Like unemployment rates, poverty rates are variable across counties: Honolulu 8.4%; Maui 9.7%; Kauai 9.5%; and Hawaii 15.0%.

The official FPL obscures the struggles faced by many families in Hawaii because of the high cost of living in the state and the generally low wage structure given the dependence of service industry jobs in tourism. The Census Supplemental Poverty Measure, which considers factors such as the cost of living and entitlements, reports that the 3-year average 2015-2017 poverty rate for Hawaii was higher than the official poverty rate of 12.3%.[10]

Wages

According to the Bureau of Labor Statistics, average annual wages for employees in Hawaii was $49,671 in 2017, $5,719 or 10.3% lower than the U.S. average of $55,390. Hawaii ranked 24th among the 50 states. Among private sector employees only, the situation is worse. Average annual wages for employees in the private sector was $47,037 in 2017, $8,301 or 15.0% lower than the U.S. average, ranking Hawaii 30th.

HIGH COST OF LIVING

Hawaii has the highest cost of living in the nation - nearly 65 percent higher than the national average. In a recent report by Forbes.com, "The Best and Worst States to Make a Living In 2017," ranked Hawaii as the worst state to make a living. The cost of living is 67% higher than what the average American pays. It also has the second-highest state income tax.

Housing Costs

The primary driver for the high cost of living is Hawaii's housing costs which are the highest in the U.S. Hawaii's high housing costs create a burden for families, resulting in less income available for other expenses needed for households to maintain optimum health. Lack of affordable housing also forces families to live in conditions that can negatively impact MCH health outcomes. Overcrowded, substandard housing, and homelessness can increase stress and family violence.

Based on data from the Honolulu Board of Realtors, in April 2019, the median housing cost for a single-family dwelling on Oahu was $766,750 and for a condominium was $418,950. The median monthly owner mortgage cost in 2017 was $2,337, $824 or 54.5% higher than the U.S. average. Among these homeowners, 29.5% spent *35% or more of their household income*, which was higher than the U.S. average of 20.7% (2017 ACS 1-year estimates).

Hawaii ranked the highest in the nation for this indicator. Not surprisingly, the homeownership rate in Hawaii in 2017 was one of the lowest in the U.S. (47th among the 50 states) at 58.5%, which was lower than the U.S. average of 63.9%.

Rental Costs

Even for working families, the high cost of fair market rent is out of reach. Based on 2017 ACS 1-year estimates, estimated 41.5% of Hawaii residents rent in 2015 (compared to 36.1% nationally). The median monthly gross rent for the renter-occupied units (excluding units not paying rent) in Hawaii in 2017 was $1,573, $561 or 55.4% higher than the U.S. average of $1,012. Hawaii had the highest cost among the 50 states.

Multi-generational Households

Another consequence of high housing costs is the high number of multigenerational households. Based on 2017 ACS 1-year estimates, the percentage of multigenerational family households among all family households in Hawaii was 11.1%, which was higher than the U.S. average of 5.9%. Hawaii had the highest rate among the 50 states.

Cost of Health Insurance

Health insurance premiums continue to increase annually and can comprise a significant amount of an individual or family's budget. According to the Hawaii State Insurance Commissioner,[11] the average health insurance group plan premium rate increase significantly declined from 2011 to 2014 to a 4% average annual increase compared to 9.3% average annual increase between 2007 and 2010. The impact of the Affordable Care Act (ACA) on individuals and family budgets/expenses has yet to be determined.

Health Services Infrastructure

According to the Hawaii State Health Planning and Development Agency, a 2017 report lists about 105 health facilities in the state.[12] These facilities include, but are not limited to, 28 hospitals,[13] 2 psychiatric only hospitals, 38 federally qualified health centers and rural health clinics.[14] Of the 28 hospitals, 12 are birthing hospitals, and 7 have psychiatric beds. A map of the location of the state's birthing hospital is in the report "Supporting Documents" section. There are three pediatric hospitals with NICUs on Oahu while other hospitals have less acute pediatric services.

There are 480 family and general practitioners, 130 obstetricians and gynecologists, and 140 pediatricians in the State of Hawaii.[15] Based on the 2017 population estimate (1,427,538), there are 9.1 obstetricians and gynecologists, and 9.8 pediatricians per 100,000 population, which are similar or slightly higher compared to the estimates in the U.S. population while the rate for family and general practitioners in Hawaii (33.6 per 100,000 population) is below the national rate (38.8).

HEALTH INSURANCE & HEALTHCARE REFORM

Hawaii has a long history of supporting initiatives to make health insurance broadly available to residents. Hawaii was among the first six states that implemented a Medicaid program in 1966. In 1974, Hawaii implemented its Prepaid Health Care Act (PHCA), which mandated that most employers make health insurance available to employees who work at least 20 hours a week.

In conjunction with the Affordable Care Act (ACA), Hawaii implemented a state-run health insurance marketplace and adopted Medicaid expansion. The marketplace transitioned to a fully federally-run exchange in 2017. Nothing changed for state Medicaid coverage with the switch to Healthcare.gov; the expanded Medicaid eligibility guidelines are still in effect in Hawaii. Through its efforts, Hawaii consistently has low uninsured rates and high overall health scores, although disparities remain.

Hawaii is one of the few states where enrollment in Health Plans through the exchange has increased every year. In 2018, 20,193 people enrolled, a 2% increase over the previous year (19,799). The major gains in coverage have

occurred through Medicaid expansion. Under the Medicaid expansion provision of the ACA, coverage increased to 138% of FPL. The number of people on the program rose significantly from 292,000 in 2013 to about 345,709 in 2018.[16] This mirrors the national average of roughly 25% Medicaid coverage of the state population. In Hawaii, Medicaid covers more than 40% of the state's children. Under ACA more than 20,000 people have enrolled in private insurance and about 53,000 people have enrolled in Medicaid.

With the possible repeal of the ACA, state lawmakers in 2018 integrated some of the more significant pieces of the legislation into the Prepaid Healthcare Act. Act 111 ensures the following ACA benefits remained available under Hawaii law:

- Ensuring dependent coverage for adult children until the age of twenty-six years;
- Prohibiting health insurance entities from imposing a preexisting condition exclusion; and
- Prohibiting health insurance entities from using an individual's gender to determine premiums or contributions.

The ACA provided state-level and provider organization-level demonstation models around innovation. Nearly 100 practices which represent several hundred primary care physicians are participating in the Comprehensive Primary Care Plus innovation program. While this is primarily a Medicare program, the impact that practice transformation occurs for all patients, regardless of the payor. The focus of the program is on screening, prevention, and care coordination.

Hawaii Medical Service Association (HMSA), the state's largest insurer, continues its effort in Payment Transformation. A majority of the state's primary care providers, as of July 1, 2018, are receiving capitated rates. This new payment model continues to receive mixed reviews from the provider community with pediatricians expressing the most concern given the intensive schedule of visits needed for infant care.

MEDICAID

The State Medicaid program is administered by the Department of Human Services (DHS) Med-QUEST Division (MQD). QUEST is an acronym that stands for: Quality Care, ensuring Universal Access, encouraging Efficient utilization, Stabilizing costs, and Transforming the way health care is provided. QUEST has 2 basic objectives: to expand medical coverage to include populations previously ineligible for Medicaid and to contain costs by shifting fee-for-service to a managed care delivery system. Savings realized from such a shift would be used to expand coverage. Under this waiver all Medicaid eligibles, excluding those with disabilities and over 65, received their services through managed care.

Hawaii's Medicaid eligibility levels for children are much higher than the national average and about average for pregnant women and parents.

- Children ages 0-18 qualify with family income levels up to 300% of the federal poverty level (FPL)
- Pregnant women qualify with family income up to 191% of FPL
- Parents and other adults qualify with family income up to 1335 of FPL.

As of September 2018, The Hawaii Medicaid Progam provided coverage to 348,607 individuals with 112,490 of them being children through traditional, SCHIP, and current and former foster care eligibility rules.[17] Additionally, the program continues to support medically needy children who are determined to need nursing home level of care.

Hawaii's SCHIP program, a Medicaid expansion, covers all children under 19 years of age with family incomes up to 300% of the FPL for Hawaii. There is no waiting period for SCHIP eligibility. All immigrant children who are Legal Permanent Residents or citizens of a COFA nation are enrolled in a Medicaid program under SCHIP.

The state continues to provide the most vulnerable COFA migrants, including the aged, blind, disabled, children and

pregnant women, with full state-funded Medicaid coverage. COFA adult migrants must enroll through Healthcare.gov. However, the state-funded Medicaid Premium Assistance Program may help, by paying the premiums for eligible COFA migrants and legally permanent residents who have incomes less than 100 percent of the FPL

Medicaid beneficiaries have a choice to select medical plans from five participating health plans: AlohaCare, HMSA, Kaiser Foundation Health Plan, 'Ohana Health Plan, and United Healthcare Community Plan. All the health plans will provide services to beneficiaries statewide, except for Kaiser Foundation Health Plan, which has chosen to operate only on the islands of Oahu and Maui.

CMS approved the Hawaii State Plan Amendment which eliminated restrictions to telehealth services. Since January 1, 2017, providers are able to provide and bill for telehealth services through Medicaid. This puts Medicaid in alignment with commercial insurance.

GOVERNMENT

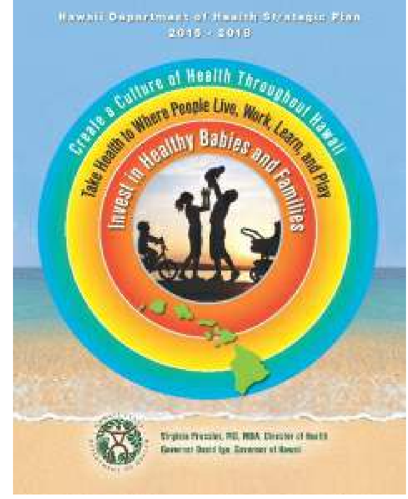
Hawaii's Executive Branch of government is organized into 16 Cabinet-level agencies. The major health programs are administered at the state level by the Department of Health (DOH) and by the DHS. DHS administers the Medicaid program; while DOH serves as the public health agency for the state. In addition to Medicaid, DHS houses the major social service/entitlement programs (Child Welfare, Temporary Assistance for Needy Families, Supplemental Nutrition Assistance Program, and Vocational Rehabilitation).

Similar to the Department of Education, DOH is the only public health agency for the state. There are no local health departments in Hawaii. The state's three neighbor island counties (Hawaii, Maui and Kauai) are represented by District Health Offices that oversee DOH staffed services at the county level. Contracted services on the neighbor islands are handled directly by the central Title V programs on Oahu.

The Governor appoints all state department directors and deputy directors; thus, the Director of Health reports directly to the Governor. The DOH is divided into 3 major administrations: Health Resources Administration (HRA), Behavioral Health (BHA), and Environmental Health (EHA). There are 6 major divisions within HRA including the Family Health Services Division (FHSD), which is responsible for the administration of all Title V funding. The three branches within FHSD are the Maternal and Child Health, Women Infants and Children (WIC) Services, and Children with Special Health Needs Branches.

Democratic Governor David Ige was re-elected to a second term in 2018. Dr. Bruce Anderson, PhD, serves as Director of Health. The former FHSD Chief, Danette Wong Tomiyasu is the DOH Deputy Director for HRA. Matthew Shim, PhD., is the FHSD Chief/Title V Director.

STATE DEPARTMENT OF HEALTH: CURRENT PRIORITIES & INITIATIVES



The current DOH Strategic Plan is currently under review by the new administration. It is anticipated the plan will remain largely the same with a greater focus on mental health issues. The three strategic plan priorities are:

A. Invest in Healthy Babies and Families;
B. Take Health Where People Live, Work, Learn, and Play; and
C. Create a Culture of Health throughout Hawaii.

Many of the strategies and activities in Title V Maternal and Child Health (MCH) 5-Year Plan fall into the Strategic Priority A.

---

[1] http://census.hawaii.gov/acs/american-community-survey-2013/

[2] Hawaii State Department of Education, English Language Learners, P. 48 of the Consolidated State Performance Report for school year 2015-16 https://www2.ed.gov/admins/lead/account/consolidated/sy145-156part1/hi.pdf

[3] COFA reports are found on https://www.doi.gov/oia/reports/Compact-Impact-Reports . The latest available update is 2017.

[4] Number of armed forces residents and military dependents at http://dbedt.hawaii.gov/economic/databook/2017-individual/_01/

[5] https://www.partnersincareoahu.org/2018-hawaii-statewide-point-time-count

[6] Report on Hawaii's economy http://dbedt.hawaii.gov/economic/qser/

[7] http://dbedt.hawaii.gov/economic/ranks/

[8] 2016 unemployment rate is found at https://www.bls.gov/lau/lastrk16.htm

[9] General fund forecast on March 15,2019, http://tax.hawaii.gov/useful/a9_1cor/

[10] Supplemental Poverty Measure is found on https://www.census.gov/library/publications/2018/demo/p60-265.html

[11] Based on the news release from the Department of Commerce and Consumer Affairs http://cca.hawaii.gov/ins/news-release-insurance-commissioner-reduces-hmsas-rate-increase-request/

[12] Based on the facility address provided on http://health.hawaii.gov/shpda/agency-resources-and-publications/health-care-utilization-reports-and-survey-instructions/2017-data/

[13] Based on information provided on http://health.hawaii.gov/ohca/medicare-facilities/hospitals/

[14] Based on information provided on https://health.hawaii.gov/docd/files/2013/07/VFC_Centers.pdf

[15] Based on 2017 state data provided in Form 11.

[16] Based on Department of Human Services, State of Hawaii, 2018 Annual Report found on http://humanservices.hawaii.gov/reports/annual-reports/

[17] Based on the 2018 enrollment report from https://medquest.hawaii.gov/en/resources/reports.html

III.C. Needs Assessment

FY 2020 Application/FY 2018 Annual Report Update

Ongoing needs assessment activities are two-fold. First, data acquisition and analysis ensure accurate information is delivered to the community in a timely manner. *Title V Federally Available Data (FAD)* remains a tremendous resource. Epidemiology staff provide basic interpretation of trends and disparate groups. However, as noted in previous reports, limitations include small sample sizes, particularly for small states like Hawaii. Therefore, Hawaii utilizes FAD aggregated multiple year estimates, as is done with local datasets, to facilitate comparison among groups.

The other limitation noted is the grouping of Asian and Pacific Islanders together. Further disaggregation is important, given that subgroups may experience different outcome rates, and therefore may not respond to the same types of interventions. Disaggregation can be done within the state, using codes from the FAD Resource Document, though smaller states have staffing limitations.

The following are the major local data sources used. Programs may access and/or collect additional data to supplement these statewide systems. These local data continue to provide community context and inform program priorities.

- The Hawaii PRAMS (Pregnancy Risk Assessment Monitoring System), administered by FHSD, continues to inform MCH programs and policies.
- DOH's Office of Health Status Monitoring (OHSM) houses the state's vital statistics.
- Hospital databases offer information around inpatient and emergency department visits.
- Self-reported data from the Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Surveillance System (YRBSS) provide context to objective data.
- Workgroups such as Hawaii's Child Death Review (CDR), Maternal Mortality Review (MMR), and Domestic Violence Fatality Review offer potential strategies for prevention and are administered by FHSD.
- Workforce data is routinely collected and reviewed by the FHSD Office of Primary Care and Rural Health (working in conjunction with the Hawaii Health Education Center) for federally designated Health Professional Shortage Area and to inform policy and planning efforts related to healthcare access. The data includes the health professions found in Form 11 as well as specialists.

Second, work with partners ensures data are contextualized to local communities and that programs remain relevant to the families served. Data are shared through a variety of venues – mainly through presentations and publications. Data dissemination aims to raise awareness of health indicators and generate discussion regarding key findings to inform actions to address health concerns.

Health status and needs of state's MCH population

Women/Maternal Health – The population of women of reproductive age (15-44 years) in Hawaii is estimated at 266,000 which represents about 19% of the state's population. For this domain, Hawaii's Title V program is focusing on preventive medical visits among women of reproductive age, which has shown improvements over time (69% in 2017, versus 55% in 2011). However, this leaves nearly one-third of women without access to preventive medical care. Subgroup analysis of 2017 data showed that Hispanic (68%) and White (62%) women were less likely to have a visit compared to Asian (76%) and Native Hawaiian and Other Pacific Islander (73%) women. Additionally, uninsured women (49%) were less likely to have had a visit, compared to those with insurance (71%). Women with less than a high school education (60%) were also less likely to have had a visit, compared to high school graduates (76%), those with some college (69%), and college graduates (65%). There were no differences based on the 2017 analysis by age, household income, or marital status.

Perinatal/Infant Health – There are approximately 23,000 pregnancies and 19,000 births every year in Hawaii. The Title V program focuses on breastfeeding and safe sleep for infants. There is no new PRAMS data; 2015 data remains the latest available. Hawaii initiation rates remain high (90.2%) and are significantly better than the nation (83.2%). The rate of exclusive breastfeeding for 6 months continues to improve – 33% in 2015, compared to 18% in 2007.

Infants being placed on their back to sleep has shown improvement between 2015 (82%) compared to 2007 (72%). There are still significant disparities, with mothers under 20 years of age (70%), 20-24 years of age (76%), Native Hawaiian (73%), and being at or below 100% of the Federal Poverty Level (FPL) (77%) or between 101-185% of the FPL having lower estimates. Updated PRAMS data will be reported next year.

Child Health – The population of children (under 9 years of age) in Hawaii is estimated to be 176,000, which represents about 13% of the state population. Hawaii's Title V program focuses on developmental screening, preventive dental visits, and the state measure on child abuse and neglect (CAN) prevention for this domain. Data from 2016-2017 show that the estimate for developmental screening was 39%; not significantly different from the national estimate of 31%. The data also shows that the estimate for preventive dental visits among children was 85%; higher than the national estimate of 80%. Due to small sample sizes, the only disparity noted was that younger children were less likely to have a preventive dental visit (69% of children 1-5 years of age, compared to 93% of children 6-11 and 91% of children 12-17). However, screening data of third graders in 2016 and 2018 data of Head Start children indicate Hawaii's children have some of the highest rates of tooth decay in the U.S.

State data from 2017 reported 1,297 confirmed child abuse victims, of which 44% occurred among children ages 0-5 years old. Some parental/family factors found in cases of confirmed CAN in Hawaii including inability to cope with parenting responsibilities (63%), drug abuse (46%), chronic family violence (15%), mental health problems (16%), spousal physical abuse/fighting (13%), alcohol abuse (9%), and lack of tolerance of the child's behavior (9%).

Adolescent Health – The population of adolescents (10-19 years of age) in Hawaii is estimated to be 165,000 which represents about 12% of the state population. Hawaii's Title V program focuses on preventive medical visits for this domain. Data for 2016-2017 show that Hawaii (75%) was similar to the national estimate of 79%. Groups more likely to have a medical visit included adolescents with a parent who is a college graduate (84%), households at 400% or higher than the FPL (86%), and those living in primarily English-speaking households (77%).

Children with Special Health Care Needs (CSHCN) – The population of CSHCN in Hawaii is estimated to be 48,000 represents 14% of the child population under 18 years of age, and 3% of the larger state population. Hawaii's Title V program focuses on transition to adult health care for this domain. Data for 2016-2017 show that the estimate for Hawaii (22%) was similar to the national estimate (17%) in those with special health care needs. The estimates in those without special health care needs were the same in Hawaii and the nation (14%). There were no significant differences in reported sub-groups.

Program capacity and systems of care

In FY 2018 FHSD had 337.5 FTE staff with 46 FTE located on neighbor islands.

Hawaii's Title V program saw the end of its five-year Centers for Disease Control and Prevention Oral Health grant in FY 2019. Hawaii's subsequent grant application was approved, but not funded. All oral health positions associated with the grant (part-time dental director and office assistant, and full-time program manager) were eliminated. Program updates are provided in the 5-year plan section for NPM-13.2.

In FY 2018 FHSD filled a vacant epidemiologist position utilizing funds from the Centers for Disease Control Preventive Health and Health Services Block Grant. The position will assist with implementation of the DOH Strategic Plan MCH components and expand FHSD data capacity overall.

In December 2018, our CDC-assigned MCH epidemiologist, Dr. Donald Hayes, resigned to accept a position at CDC in Atlanta. FHSD is awaiting information about a possible replacement in October 2019.

Partnerships and collaborations

Partnerships among Hawaii's Title V programs continue to be robust and varied. One of FHSD's most important partners is the Department of Human Services (DHS) which administers the major federal social service/entitlement programs including Medicaid, Temporary Assistance for Needy Families, Food Stamps, Child Welfare Services, Childcare subsidies, and Vocational Rehabilitation. The DHS Government Transformation initiative, *'Ohana Nui* ('extended family' in Hawaiian), continues. Employing a Two-Generation best practice approach, the process is designed to improve and coordinate service delivery to break the cycle of intergenerational poverty.

Collaboration between DOH and DHS has increased with 'Ohana Nui (ON). Together, the agencies are identifying opportunities for greater collaboration by leveraging resources (e.g., technical assistance, subject matter expertise, and data). The partnership with DHS allows FHSD to expand its reach, particularly to the State's most vulnerable families, thereby addressing many of the social determinants of health. Partnership examples can be found throughout the report:

- Assistance to integrate a prevention focus in Child Welfare Services,
- Promotion of reproductive health planning and increasing access to contraceptive care in partnership with Medicaid,
- Implementation of the state Child Care program policy for mandated Safe Sleep training of all licensed child

care providers, and
- Development of a new Title V-Medicaid Inter-Agency Agreement (a draft currently in progress in Section IV).

FHSD continues its partnership with One Shared Future (OSF), the firm established by the former DHS Director responsible for ON, which support government transformation efforts by building skills and knowledge to support innovation in the public sector. FHSD staff participated in two training series with DHS program managers and attend follow-up meetings of OSF training graduates from across state departments. A modified OSF training was also brought to FHSD (see description in MCH Workforce Development).

Key public-private partnerships continue including:
- Both the Hawaii Maternal and Infant Health Collaborative (HMIHC) and the Early Childhood Action Strategies (ECAS) are multi-disciplinary/public-private partnerships working to improve healthy births and child outcomes. FHSD staff serve in leadership positions.
- Child Death Review, Maternal Mortality Review, Domestic Violence Fatality Review are multi-disciplinary groups that review cases to provide recommendations for prevention efforts.
- The Early Language Working Group makes recommendations to support age-appropriate language development for children age 0-5 years who are deaf, hard of hearing, or deaf-blind.

In FY 2018, the Office of Primary Care & Rural Health began working with the Hawaii Primary Care Association and its Federally Qualified Health Centers members to administer the state Community Health Center Special Fund. The fund ensures healthcare services remain viable for Hawaii's uninsured/underinsured residents in rural and medically underserved areas. Activities include: monitoring contracts, addressing administrative issues, and responding to emerging community health needs.

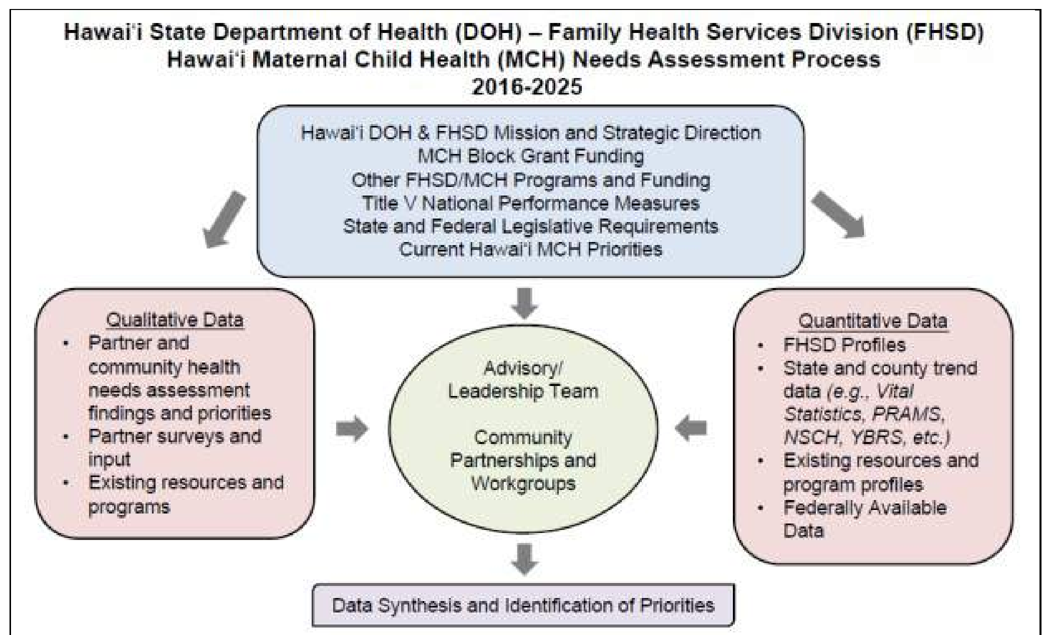
Efforts to operationalize needs assessment

Hawaii's Title V team continues to assure needs assessment is more systematic and integrated into ongoing operations. Program managers across the FHSD provide leadership for the Title V priorities, and the reporting process is used to help build/strengthen staff public health capacity. Dr. Jeanelle Sugimoto-Matsuda with the University of Hawaii Office of Public Health Studies (OPHS) continues to work with staff to strengthen assessment and evaluation. Program progress, achievement of short- and long-term outcomes, and alignment of strategies are reflected in logic models developed for the national performance measures. Logic models for FY 2018 are included in the State Plan narratives and Supporting Documents.

2020 Needs Assessment Planning

The 2020 needs assessment process (NA) generally follows the 2015 process. The process was developed with FHSD managers, staff, and key external stakeholders and is comprised of two phases:
- Issue/Priority Identification/Selection of National and State Title V Performance Measures to be completed in October 2019
- 5-Year Plan with strategies, objectives, strategy measure to be completed May 2020.

As in 2015, many of the same data sources/data collection methods will be utilized; leadership structure; and priority selection criteria. The graphic below provides a general overview of the process.



Changes to the 2020 process were shaped by ideas shared nationally by other state Title V programs through presentations, peer-to-peer TA sessions, and the AMCHP NA TA Series. Improvements include: guiding principles, guidelines for the process, the formation of an FHSD NA collaboration group, a stronger health equity focus, and greater effort on communications. Also new, FHSD secured services for NA planning/implementation, communications consulting and graphic design. Also, a workplan was completed in April 2019. See the Supporting documents more detailed information.

Needs Assessment (NA) Collaborative Group

The FHSD NA collaborative group was convened to facilitate cross-project sharing among programs conducting or participating in NA. Members include staff from Title V, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, the CAN Prevention (CANP) Program, the State Primary Care Office, and the Early Childhood Systems Coordinator. The group has identified areas of overlap (including data needs), identified other state/community planning efforts to integrate the NAs, and is leveraging resources.

The two contracted needs assessment consultants for Title V and CANP (Dr. Sugimoto-Matsuda) and MIECHV (Dr. Elizabeth McFarlane) are both faculty colleagues at the University (OPHS) which supports coordination. Dr. McFarlane has previous experiences working the MIECHV program as well as providing TA for with the Pacific Jurisdictions Title V programs.

The NA/plans being reviewed as part of the NA collaborative:

- State Hospital Community Health Needs Assessment required under the federal ACA
- Hawaii Department of Human Service's Child and Family Service Plan (CFSP) for 2020-2024.
- Hawaii Injury Prevention Plan, 2018-2023 guiding document for injury prevention activities under DOH's EMS and Injury Prevention System Branch.
- State Head Start programs' self-assessments and community profiles.
- Preschool Development Grant (PDG)
- the Early Childhood State Plan completed by Hawaii Executive Office on Early Learning.

FY 2019 Application/FY 2017 Annual Report Update

Ongoing needs assessment activities are two-fold. First, data acquisition and analysis ensure accurate information is delivered to the community in a timely manner. *Title V Federally Available Data (FAD)* remains a tremendous resource. Epidemiology staff provide basic interpretation of trends and disparate groups. However, as noted in previous reports, limitations include small sample sizes particularly for small states like Hawaii. Hawaii will benefit from the FAD aggregated multiple year estimates, as is done with local datasets, to facilitate comparison among groups.

The other limitation noted last year is the grouping of Asian and Pacific Islanders together. Further disaggregation is important, given that subgroups may not respond to the same types of interventions. Disaggregation can be done within the state, using codes from the FAD Resource Document, though smaller states have staffing limitations.

The following are the major local data sources used. Programs may access and/or collect additional data to supplement these systems. These local data continue to provide community context and inform program priorities.

- The Hawaii PRAMS (Pregnancy Risk Assessment Monitoring System), administered by FHSD, continues to inform MCH programs and policies.
- DOH's Office of Health Status Monitoring (OHSM) houses the state's vital statistics.
- Hospital databases offer information around inpatient and emergency department visits.
- Self-reported data from the Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Surveillance System (YRBSS) provide context to objective data.
- Workgroups such as Hawaii's Child Death Review (CDR) and Maternal Mortality Review (MMR) offer potential strategies for prevention and are administered by FHSD.
- Workforce data is routinely collected reviewed by the FHSD Office of Primary Care & Rural Health to identify and maintain federally designated Health Professional Shortage Areas.

Second, work with partners ensures data are contextualized to local communities and that programs remain relevant to the families served. Data are shared through a variety of venues – mainly through publications and oral presentations. While specific formats and timing vary by program, dissemination generally aims to raise awareness of health indicators, develop capacity for the state, and contribute to ongoing needs assessment activities. Dissemination efforts are summarized under their relevant domain. FHSD staff facilitate mechanisms by which discussions and resulting recommendations can be recorded and integrated into program implementation.

Health status and needs of state's MCH population

Women/Maternal Health – The population of women of reproductive age (15-44 years) in Hawaii is estimated at 266,000 which represents about 19% of the state's population. For this domain, Hawaii's Title V program is focusing on preventive medical visits among women of reproductive age, which has shown improvements over time (67% in 2016, versus 55% in 2011). However, this leaves nearly one-third of women without access to preventive medical care. Among this one-third, White (61%), Japanese (57%), and Other Pacific Islander (55%) women are less likely to have a visit compared to Filipino (70%) women. Additionally, uninsured women (52%) are less likely to have had a visit, compared to those with insurance (65%).

Recent dissemination efforts include:

- Peer-reviewed publication in *Maternal and Child Health Journal* – The relationship of adverse childhood events (ACEs) to smoking, overweight, obesity, and binge drinking among women in Hawaii – more than half of adult women reported at least one ACE. The paper highlights the relationship between ACEs and impacts in adult life.
- Presentations:
  - Hawaii Maternal and Infant Health Collaborative (HMIHC) – interpregnancy interval.
  - Hawaii PRAMS steering committee – indicators for use in upcoming trend report.
  - AMCHP conference – training providers on One Key Question.
  - Bright Smiles Hawaii workgroup – treatment in emergency departments (EDs) for oral health issues.

Perinatal/Infant Health Domain – There are approximately 23,000 pregnancies and 19,000 births every year in Hawaii. The Title V program focuses on breastfeeding and safe sleep for infants. The rate of exclusive breastfeeding for 6 months continues to improve – 30% in 2014, compared to 18% in 2007.
Infants being placed on their back to sleep also improved – 82% in 2015, compared to 72% in 2007. However, there are still significant disparities, with mothers under 20 years of age (70%), 20-24 years of age (76%), Native Hawaiian (73%), and being on Medicaid/QUEST during prenatal care (76%) having lower estimates.

Recent dissemination efforts include:

- Safe Sleep Committee and the Keiki Injury Prevention Coalition – sudden unexpected infant death.
- Child Death Review program summit – leading causes of infant death in Hawaii.
- Presentation on infant hearing loss – Hawaii's high rates of permanent congenital hearing loss.

Child Health – The population of children (under 9 years of age) in Hawaii is estimated to be 176,000, which represents about 13% of the state population. Hawaii's Title V program focuses on developmental screening, preventive dental visits, and the state measure on child abuse and neglect prevention for this domain. Due to small sample sizes, the only disparity noted was that younger children were less likely to have a preventive dental visit (65% of children 1-5 years of age, compared to 93% of children 6-11 and 91% of children 12-17).

Recent dissemination efforts include:

- Peer-reviewed publication in *Child Abuse and Neglect* – Adverse family experiences and flourishing amongst children ages 6-17 years: 2011/12 National Survey of Children's Health – children with ACEs were less likely to flourish, compared to those without ACEs.
- Presentation at the Council of State and Territorial Epidemiologists (CSTE) conference – lack of dental care among third graders.

Adolescent Health – The population of adolescents (10-19 years of age) in Hawaii is estimated to be 165,000 which represents about 12% of the state population. Hawaii's Title V program focuses on preventive medical visits for this domain. Although just one year of data is available thus far, some differences were seen. Groups more likely to have a medical visit included adolescents with a parent who was a college graduate (85%), households at 400% or higher than the Federal Poverty Level (86%), and those living in primarily English-speaking households (76%).

Recent dissemination efforts include:

- CSTE conference – risk of suicide among Hawaii public middle and high school students and overall reduction in teen births, but some persistent disparities.
- American Public Health Association – risk behaviors relating to oral health among youth.

Children with Special Health Care Needs (CSHCN) – The population of CSHCN in Hawaii is estimated to be 42,000 which represents 14% of the child population under 18 years of age, and 3% of the larger state population. Hawaii's Title V program focuses on transition to adult health care for this domain. The numbers available for detailed analysis are limited at this time, with no differences seen among subgroups.

Program capacity and systems of care

Hawaii's Title V program capacity expanded with new program funding. New program areas include the reinstitution of the Child Death Review program and establishment of a new Maternal Mortality Review through passage of State Act 203 in 2016. The CSHNB received Childhood Lead Poisoning Prevention (CLPP) funding from Centers for Disease Control and Prevention (CDC) to reduce lead exposure and lead poisoning of children from birth through five years of age; strengthening blood lead level testing, surveillance, population-based interventions, and identify lead-exposed children and link to services.

The impact of WIC's reductions-in-force (RIF) last year has been addressed by the Branch. Most of the eliminated positions

were already vacant given decreasing clients enrollments. Caseload ratios are being adjusted, efficiencies identified, and efforts dedicated to increase WIC participation.

Partnerships and collaborations

Partnerships among Hawaii's Title V programs continue to be robust and varied. Updates regarding new partnerships are highlighted below.

One of FHSD's most important partners is the Department of Human Services (DHS) which administers federal social service/entitlement programs targeting families. DHS programs include Medicaid, Temporary Assistance for Needy Families, Food Stamps, Child Welfare Services, Childcare subsidies, and Vocational Rehabilitation. DHS has undertaken a 'Government Transformation' process called Ohana Nui (extended family). Employing the Two-Generation best practice approach, DHS is working to transform service delivery to address the needs of children, parents, and grandparents early and concurrently, resulting in better outcomes for the family. Implementing this new philosophy requires tearing down silos, thinking beyond the limitations of funding streams, and work across divisions, programs, and teams. The process is designed to improve and coordinate service delivery across the department to break the cycle of intergenerational poverty.

FHSD was invited to formally partner in the Ohana Nui (ON) process by participating in an 8-week professional development training to support the top cadre of DHS managers responsible for 'engineering' the ON organizational changes. The training was conducted by One Shared Future, a firm established by the former DHS Director, to build skills and knowledge for innovation in the public sector. The partnership with DHS allows FHSD to expand its reach to the State's most vulnerable families; thereby, addressing many of the social determinants of health. Together, the agencies are identifying opportunities for greater collaboration by leveraging resources; technical assistance, subject matter expertise, data as well as access to families and service providers. The partnership will help create a more seamless system of family services for the state. Evidence of the partnership can be found throughout the report.

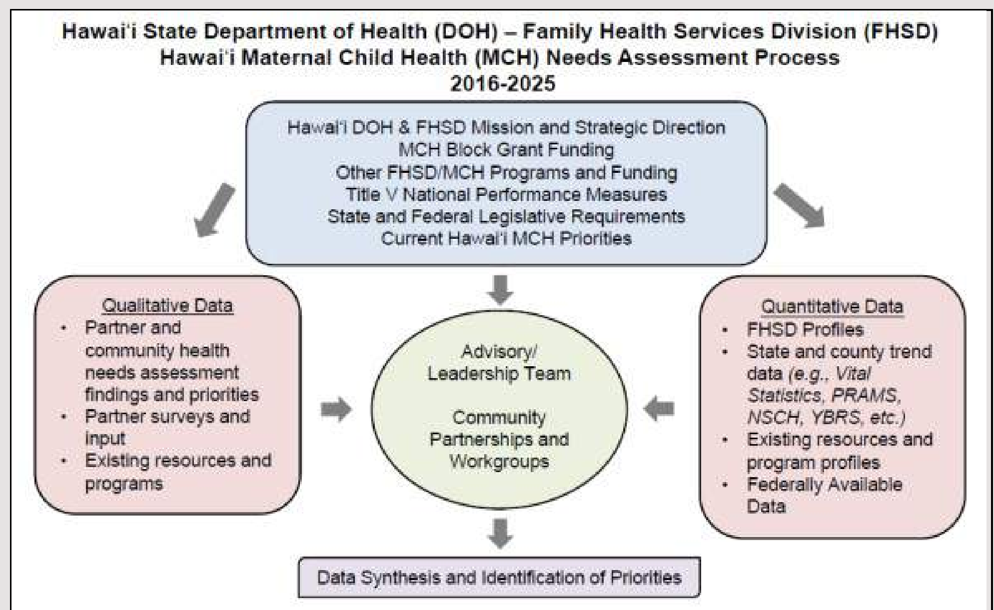
Existing public-private partnerships continue. Highlights include:

- Both the Hawaii Maternal and Infant Health Collaborative (HMIHC) and the Early Childhood Action Strategies (ECAS) are multi-disciplinary/public-private partnerships working to improve healthy births and child outcomes, starting with the health of reproductive age women. FHSD staff serve in leadership positions and participant in sub-committees for both initiatives.
- Case review workgroups – i.e., Child Death Review and Maternal Mortality Review – are multi-disciplinary groups that review death cases and provide recommendations to improve prevention efforts.
- The Early Language Working Group makes recommendations to support age-appropriate language development for children age 0-5 years who are deaf, hard of hearing, or deaf-blind.

Needs Assessment Planning

The 2015 needs assessment informed, and continues to guide, FHSD health programs and systems that serve Hawaii's women, infants, and children. The process is iterative and integrates multiple partnerships and data sources, as depicted in the figure below. Plans have begun for the 2020 Title V five-year needs assessment, which will utilize a similar process and

framework, and build upon the ongoing data and recommendations that have emerged since the 2015 assessment.



Efforts to operationalize needs assessment

Hawaii's Title V team continues to identify strategies that will make the ongoing needs assessment process more systematic and integrated into operations. Program managers across the Division provide leadership for the Title V priorities and the reporting process is used to help build/strengthen staff public health capacity. During FY 2018, FHSD partnered with Dr. Jeanelle Sugimoto-Matsuda, to introduce methods to improve Title V assessment, as well as increase consistency across programs. Dr. Sugimoto-Matsuda is a faculty member with the University of Hawaii Office of Public Health Studies. Trained in public health and translational research, she brings formal background in assessment and evaluation methods. FHSD staff and Dr. Sugimoto-Matsuda reviewed program progress, achievement of short- and long-term outcomes, and alignment of strategies with intended outcomes.

Logic models were introduced for each of the national performance measures as recommended at 2018 AMCHP skills building sessions. Logic models are widely used tools in public health for both planning and evaluation. The five major parts of the logic model are: resources, activities, short-term outputs, longer-term outcomes, and contextual conditions (e.g., conditions beyond our control that must be considered such as culture, rurality, health and service gaps, and socioeconomic conditions). Logic models were used to map out each program's strategies, expected outcomes, and also to guide assessment of alignment and appropriateness among strategies, short-term measures (i.e., evidence-based strategy measures) and longer-term measures (i.e., national performance and outcome measures). Title V staff partnered with Dr. Sugimoto-Matsuda on the assembly and review of each logic model. For a few domains, minor adjustments were identified during this phase of the needs assessment process. Logic models are included and referenced in the State Plan narratives.

Changes in organizational structure and leadership

FHSD now has 277 FTE staff, of which 18.1 FTE are Title V-funded. Also, 46 FTE are located on neighbor islands. After the loss of 44 WIC positions in 2017 (many of which were vacant due to decreasing caseloads), the FHSD workforce has remained relatively stable.

In 2017, FHSD made major progress filling key vacant program positions:

- Wendy Nihoa serves as the new PRAMS Coordinator, bringing 15 years of public health management and leadership experience to the program.
- FHSD filled to key administrative positions: the Division Administrative Officer, Lane Aakhus, and Division Accountant, Christine Kok.
- Leadership and staffing positions for the State Oral Health Program positions have been filled. FHSD also

submitted a new CDC oral health funding application and is waiting award announcements for the competitive 5-year grants.

Recruitment continued for an Epidemiologist II for the Division Surveillance, Evaluation, and Epidemiology Unit. The position was filled in 2018 and is temporarily funded using the CDC Preventive Health and Health Services Block Grant administered by the DOH Planning Office. Permanent funding will be sought.

CSHNB filled the newly established Early Childhood Program Specialist position in the Children and Youth with Special Health Needs Section. This position will address early childhood issues, including developmental screening, with a focus on children with special health care needs.

FY 2018 Application/FY 2016 Annual Report Update

II.B.1. PROCESS

Ongoing needs assessment activities include developing and publishing various data reports, data analyses, special studies, work with partners, other collaborative activities, and regular review of data by workgroups to ensure appropriate progress and that activities improve health of families.

Publications in peer-review journals included: underdiagnosis of conditions associated with sudden cardiac death in children; relationship of adverse childhood events to smoking, binge drinking, overweight and obesity among women in Hawaii; improving health for mothers, infants, and families with the Hawaii maternal and infant health collaborative; and physician survey assessing pelvic inflammatory disease knowledge and attitudes to identify diagnosing and reporting barriers.

The Relationship of Adverse Childhood Events to Smoking, Overweight, Obesity and Binge Drinking Among Women in Hawaii

Presentations for community stakeholders and others raise awareness of various health indicators and contribute to ongoing needs assessment activities. Presentations in the past year included: maternal and child morbidity and mortality, teen pregnancies and births, adolescent suicide ideation, safe sleep and sudden unexpected infant deaths, and utilization of claims based data to assess preventable oral health visits at emergency departments.

The Hawaii State Office of Primary Care and Rural Health (HSOPCRH) is partnering with the Hawaii/Pacific Basin Area Health Education Center (AHEC) of the John A. Burns School of Medicine to develop the health professional workforce. Hawaii's health professional workforce shortage is profound. Over 650 physicians are needed, with the deficiency growing by 60 physicians a year. Half that shortage is in primary care. When physician assistant and advanced practice registered nurse numbers are included, Hawaii is over 450 primary care providers short. This project will update Hawaii's baseline of health provider data of physicians and dentists statewide using the National Provider Identifier (NPI) registry, Professional and Vocational Licensing (PVL) listmaker, the Shortage Designation Management (SDM) system. The data resulting from this collaboration will allow both partners to assess and project health workforce shortage areas in the State of Hawaii.

The FHSD OPCRH completed its facilitation of **Community Health Needs Assessments** (CHNA) at a rural critical access hospital (CAH), Kahuku Medical Center (KMC) on Oahu. Under the Affordable Care Act (ACA), all non-profit hospitals are required to complete this assessment once every 3 years. The CHNA process allows community members the opportunity to provide input on community health concerns in a neutral environment. The KMC completed their second CHNA process, fulfilling their requirements for the next 3-year cycle.

The **Title V Federally available data** (FAD) serves as a tremendous resource to report consistent data across programs. The epidemiology staff uses the data to provide some basic interpretation of trends and disparate groups as part of the ongoing needs assessment process and with the latest application. In general, the data is very useful, but would be more helpful if there was an emphasis on more timely data across programs through the Infant Mortality CoIIN initiatives.

Additionally, it would be helpful for small states to have the stratifiers aggregated by multiple years due to small numbers in order to have more refined estimates to facilitate comparison among groups. This is done for maternal mortality and perinatal mortality, but not for others such as VLBW. This analysis is routinely done in Hawaii when it comes to PRAMS and vital statistics data where annual trends are reported, followed by 3 year (or more) aggregates to obtain more stable and reliable estimates.

Other issues include the presentation of race estimates where Asian and Pacific Islanders are grouped together for the majority of the data; however, the data from the children surveys separate out Asian and NHOPI into separate categories and include a multiple race grouping. In Hawaii, the composite Asian group is the largest race group with NHOPI close behind with populations sufficiently large to provide those estimates. Much of this analysis can be done within the state, but small states tend to have limited staff. The inclusion of actual programming code in the FAD Resource document is very helpful to ensure consistent calculations and to help improve capacity of states to analyze these data sources. In objective settings, the 2016 application was reviewed where the 2020 objective was set at 5% over baseline at time of submission. In this application, interim objectives were included to meet that 2020 estimate. Additionally, the 2020 estimate was carried over to 2021 as no significant changes were seen in NPM with new data that warranted a change in the 5-year objective.

Hawaii is up to date with data submission to the **IM CoIIN**. Despite the reduction in the infant mortality rate seen in the FAD, the provisional quarterly data submitted to CoIIN showed overall increases in infant deaths for 2015 and 2016, particularly around SUID deaths. The ongoing work of Safe Sleep Hawaii, the Hawaii Maternal and Infant Health Collaborative, and the Child Death Review are all aware of the increase in SUID deaths and planning efforts are underway to promote a safe sleep environment.

Effective May 2017, a new Program Coordinator, Wendy Nihoa, joined the **HI-PRAMS** program. Ms. Nihoa brings more than 15-years' experience in public health with a focus on chronic disease prevention, substance abuse treatment, strategic planning and capacity building.

The HI-PRAMS continues to serve as a critical source of data informing MCH programs, policies and the overall effort to reduce infant mortality and promote maternal health. In addition to daily operations associated with managing the PRAMS Integrated Data Collection System (PIDS), HI-PRAMS will focus on:

Developing a communication and marketing plan;
Improving ease of access to PRAMS data;
Reviving the PRAMS Steering Committee;
Collecting and reporting Data-To-Action stories;
Improving quality of PIDS Data; and
Participating in community-based collaborations/committees.

FHSD received Hawaii PRAMS 2013 data in May 2017 and started initial analyses of the data, prioritizing safe sleep risk factors. Analyses of PRAMS data will be supported by a MCH Bureau summer intern.

II.B.2. FINDINGS

II.B.2.a. MCH POPULATION NEEDS

Child well-being: The *2016 KIDS COUNT Data Book* showed that Hawaii ranks 23rd in the US in overall child well-being. Hawaii data showed improved rates for health (low-birthweight babies, children without health insurance, child/teen deaths, teens who abuse alcohol or drugs). However, rates worsened for economic well-being (poverty, parental employment, teen not in school/not working), education (young children not in school), and family/community (single-parent

families, living in high-poverty areas).

II.B.2.b. TITLE V PROGRAM CAPACITY

II.B.2.b.i. ORGANIZATIONAL STRUCTURE

Through reorganization, CSHNB established a new Children and Youth Program Specialist IV position in the Children and Youth with Special Health Needs Section. This position will address early childhood issues, including developmental screening, with a focus on children with special health care needs.

II.B.2.b.ii. AGENCY CAPACITY

The Genomics Section of the CSHNB is administering a new Centers for Disease Control grant for surveillance, intervention, and referral for infants with microcephaly or other adverse outcomes linked with the Zika virus. The funding and technical assistance will enable the Hawaii Birth Defects Program to engage in surveillance, collaboration, and data utilization activities. The Genomics Section will also be helping link providers and families with or at risk for birth defects, to available resources and services. An update on the Zika virus activities can be found in Section II.F.5 on Emerging Issues.

II.B.2.b.iii. MCH WORKFORCE DEVELOPMENT AND CAPACITY

FHSD now has FTE 277 staff, of which 19.1 FTE are Title V funded, and 42 FTE are located on neighbor islands. The agency overall continues to lose staffing most recently in the WIC Services Branch. WIC instituted a reduction-in-force (RIF) in response to a federal budget shortfall in FFY 2017, resulting in 44.5 of 116.5 positions being eliminated as of July 2017. Positions were eliminated based on the declining participation rates in Hawaii and an adjusted staffing formula based on a productivity ratio of 325 participants per full-time-equivalent for direct service staff. Direct services are also provided by contractors, mostly FQHCs. State agency support staff positions were also eliminated. The RIFs will likely increase workload for remaining State agency staff. The rollout of the new web-based management information system by June 2017 presents increased telehealth service possibilities that were not possible with the old system.

FHSD filled the FHSD Chief position in 2016. Matthew Shim, PhD, MPH began serving as the FHSD Chief in October 2016. Dr. Shim holds Bachelor's and Master's degrees in Psychology, a Master's degree in Public Health, and a Doctorate in Epidemiology. He has more than 20 years of experience in public health administration, serving as a Public Health Officer in many different leadership roles within the U.S. Air Force.

In 2017 the half-time Dental Director position was filled by Dr. Gavin Uchida, a pediatric dentist, in private practice and who also works at Shriners Hospital.

Recruitment continues for key FHSD positions including the Division's Public Health Administrative Officer (vacant since 2014) and Secretary. Recruitment also continues for an Epidemiologist II supervisor for the Surveillance, Evaluation, and Epidemiology Unit. The position will be funded by the CDC Preventive Health and Health Services Block Grant temporarily till permanent funding can be secured.

II.B.2.c. PARTNERSHIPS, COLLABORATION, AND COORDINATION

Partnership with other DOH agencies:

- FHSD staff and the Office of Planning, Policy, and Program Development are continuing working together on the MCH components of the DOH Strategic Plan and oral health projects.
- CSHNB staff are continuing work with Hazard Evaluation and Emergency Response Office, Indoor Radiological Health Branch, and Public Health Nursing Branch on childhood lead screening and follow-up.

Partnership with other state agencies

Partnerships between FHSD and the state Department of Human Services (DHS) increased substantially under the current Administration. Examples are highlighted in the 5-year plan report in Section II.F.1. Additional projects are:

- Family receiving SNAP, TANF, TANOF are adjunctively income-eligible for WIC. All WIC enrolled families receive a DHS brochure on benefits.
- WIC and DHS collaborate to ensure timely services to homeless pregnant and postpartum moms and families with

young children. DHS can directly refer clients to WIC clinic operations staff to expedite enrollment.

The FHSD Early Childhood Coordinator is working with DHS-Child Care program to increase supports for providers working with infants and toddlers. The development of an infant-toddler specialist mental health/behavioral network is being explored.

Early Intervention Services and the Children Welfare Services (CWS) are collaborating to identify children under age 3 who may qualify for EI services under Part C of IDEA, who are involved in substantiated cases of child abuse or neglect; and creating a seamless system of referral and services for families served by both CWS and EIS. A Memorandum of Agreement is being updated.

Children and Youth with Special Health Needs Section (CYSHNS) presented its transition efforts at a DHS EPSDT meeting on Current Supports for Children Transitioning to Adulthood.

Public-private partnerships

Public-private partnerships described in previous years continue. New initiatives include:

Act 203, passed in 2016, established the authority and resources to conduct reviews of child and maternal deaths. Funding for the child death review (CDR) program was lost due to budget cuts. Maternal mortality review (MMR) is a new programmatic area for Title V. During 2016 -2017 the Title V MCH Branch contracted for a CDR coordinator and a MMR coordinator and abstractor. CDR policies were revised and MMR policies and procedures were developed. CDR and MMR trainings were held in November 2016-2017.

CDR Reviews are held on Oahu, Maui, Kauai, and Hawaii Island. Members of the team include: fire and police, coroner's office, social service agencies, first responders, public health nursing, judiciary, and ad hoc members as appropriate. Recommendations following the reviews are presented to the CDR Council for specific action to reduce the occurrence of preventative child deaths.

From 2016-2017, 150 CDR reviews were completed. The MMR will hold its first review on July 31, 2017. A permanent full-time registered nurse position was established to serve as the CDR/MMR coordinator.

In addition, a new Collaborative Death Review team that includes members of other state CDR and supporting agencies (Developmental Disabilities Division, Kapiolani Medical Center, DHS, and Child and Adolescent Mental Health Division, ACOG, Vital Statistics, University of Hawaii, School of Nursing and Dental Hygiene, and others) was created. This review team will assist in identifying strategies to reduce preventable deaths, develop a quality review system, serve as a resource network for the review teams, and provide recommendations for system change.

The **Early Language Working Group** (ELWG) was established by Act 177 of the 2016 State Legislature. The purpose of the ELWG is to make recommendations to the legislature on issues related to supporting age-appropriate language development for children age 0-5 years who are deaf, hard of hearing, or deaf-blind (D/HH/DB). ELWG members include 4 parents. The majority of members are required to be D/HH/DB. The ELWG was convened by the DOH (CSHNB), Department of Education, and Executive Office on Early Learning (EOEL). Meetings are facilitated by the Hilopaa F2FHIC Director, with the support of CSHNB. An interim legislative report was submitted in December 2016.

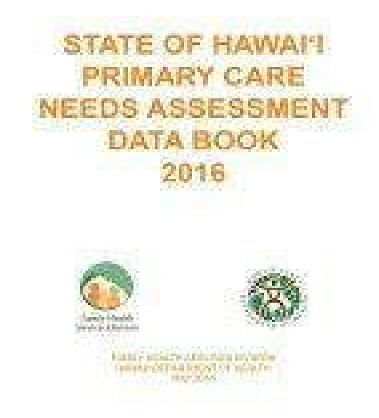
2017 Legislation

SB501 was signed into law and requires all limited service pregnancy centers to disseminate a written notice on the availability of and enrollment information for publicly-funded family planning services; to adhere to privacy and disclosure requirements for client records; and establishes civil penalties for noncompliance and authorizes enforcement actions. The new law assures individuals seeking reproductive healthcare receive comprehensive, accurate, unbiased information in a confidential setting.

FY 2017 Application/FY 2015 Annual Report Update

II.B.1. PROCESS

Ongoing needs assessment activities include developing and publishing various data reports, data analyses, special studies, work with partners, other collaborative activities, and regular review of data by workgroups to ensure appropriate progress and that activities improve health of families.



Primary Care Needs Assessment Data book (2016), completed by FHSD, presents indicator data for multiple data sources at the community level including data from the US Census, American Community Survey, Vital Statistics, Behavioral Risk Factor Surveillance System, and Hospital Discharge data. Significant geographic disparities are seen across socioeconomic, maternal and infant health, chronic disease risk factors, mortality, oral health, and hospitalizations for mental health and substances related disorders. **The data book reflects the broad perspective of primary care including chronic disease morbidity and mortality and other traditional maternal and infant health outcomes such as infant mortality and access to prenatal care.** Dissemination of the data book to stakeholders and partners, and use of maps and data in presentations are some ways that data are used as part of FHSD ongoing needs assessment**.**

Data analyses help inform the ongoing needs assessment process. Data analyses since the last application that have been accepted for presentation at conferences include: disparities in screening for alcohol use, community level income and its association with extremely preterm births, prevention of recurrent preterm delivery, increased rates of severe maternal morbidity, prenatal smoking and neonatal intensive care unit admissions, attitudes towards fluoride supplementation among pediatric providers, variation in need for dental treatment among 3rd grade children, bullying behavior and associated impacts among middle and high school students, race/ethnic and other disparities in oral health utilization among adolescent and adults, risk factors for teen pregnancy, trends in breastfeeding patterns among race/ethnic and socio-economic diverse groups, and utilization of GIS technology to visualize community level data.

Birth Defects and Newborn Screening Programs periodically analyze their population-based data.

Special studies – See Oral health/Hawaii Smiles below.

Publications in peer-review journals included: underdiagnosis of conditions associated with sudden cardiac death in children; depression, anxiety, and pharmacotherapy around the time of pregnancy; and predictors of dental cleaning over a two-year time period around pregnancy among Asian and Native Hawaiian or Other Pacific Islander race subgroups.

Presentations for community stakeholders and others raise awareness of various health indicators and contribute to ongoing needs assessment activities. Presentations in the past year included: maternal and child morbidity and mortality, teen pregnancies and births, adverse childhood and family experiences, infant mortality trends, safe sleep, sudden unexpected infant deaths, early term deliveries and increased newborn intensive care unit hospitalizations, public health and longitudinal data linkages, perinatal substance use, and infant/toddlers.

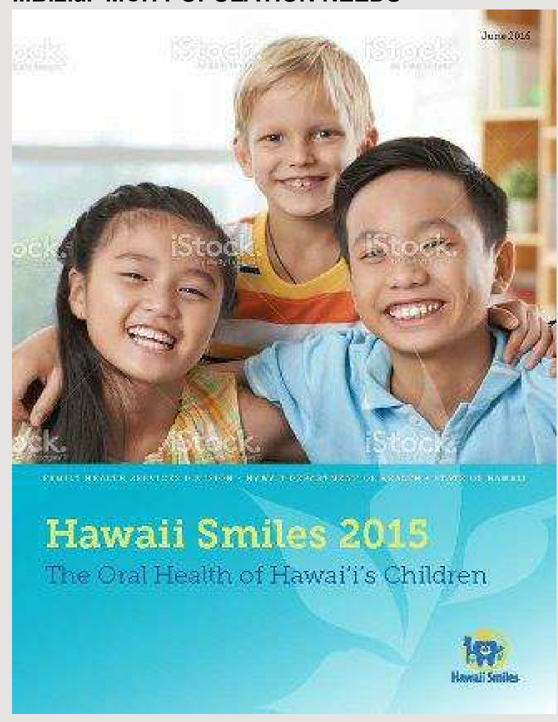
Community Health Needs Assessments (CHNA):

The FHSD Office of Primary Care and Rural Health (OPCRH) continues in 2016 its facilitation of CHNA at a rural critical

access hospital (CAH) on Oahu. The assessment process takes several months from initial data collection, survey development, compilation of findings, strategy prioritization, and completion/public dissemination of a final hospital report. CHNAs represent the start of community conversations and collaborations, and often inform other health assessments and strategic plans in Hawaii. OPCRH is also developing brief community health profiles for each CAH or rural community as requested.

II.B.2. FINDINGS

II.B.2.a. MCH POPULATION NEEDS



Oral health: FHSD studied the oral health status of a representative sample of third grade children throughout the state during the 2014-2015 school year. The “Hawaii Smiles” (forthcoming 2016) report showed that Hawaii has the highest prevalence of tooth decay among third graders in the US, with 71% affected by tooth decay (higher than the US average of 52%); 22% have untreated tooth decay, showing the need for dental care; about 7% need urgent dental care because of pain or infection; and over 60% do not have protective dental sealants. Oral health disparities are significant, with low-income and Micronesian, Native Hawaiian, Other Pacific Islander, and Filipino children having the highest level of untreated decay and decay experience. Third graders living in Kauai, Hawaii, and Maui counties are more likely to have tooth decay than those in Honolulu County. Findings support the need for culturally appropriate community-based prevention programs, screening and referral services, and restorative dental care to improve the oral health of Hawaii’s children.

Child well-being: The *2016 KIDS COUNT Data Book* showed that Hawaii ranks 23rd in the US in overall child well-being. Hawaii data showed improved rates for health (low-birthweight babies, children without health insurance, child/teen deaths, teens who abuse alcohol or drugs). However, rates worsened for economic well-being (poverty, parental employment, teen not in school/not working), education (young children not in school), and family/community (single-parent families, living in high-poverty areas).

Zika virus infection: In January 2016, DOH received laboratory confirmation of congenital Zika virus infection in a microcephalic infant born in Hawaii to a mother who emigrated from Brazil early in her pregnancy. For the period 2015-2016, as of 6/29/16, Hawaii had 10 travel-related cases who were infected outside of Hawaii. No cases were acquired locally. While Zika virus is not endemic in Hawaii, it is transmitted by Aedes species mosquitoes which can be found throughout Hawaii. A concern is that Zika cases among travelers visiting or returning to Hawaii may result in the Zika virus becoming endemic and spreading locally. Needs in Hawaii related to MCH include: monitoring Zika-infected pregnant women through pregnancy and their infants through the first year of life, information sharing, disseminating DOH materials to families/community, etc. See Emerging Issues for more information about Zika.

II.B.2.b. TITLE V PROGRAM CAPACITY

II.B.2.b.i. ORGANIZATIONAL STRUCTURE

A new safety net program in Children with Special Health Needs Branch (CSHNB) is Hiilei Hawaii Developmental Follow Along Program for Young Children, which provides developmental screening for young children who are not eligible for early intervention (EI) services under Part C of the Individuals with Disabilities Education Act.

A 2016 reorganization of the CSHNB/Children and Youth with Special Health Needs Section increased its capacity to develop and promote health/developmental services for children with special health care needs, with a focus on early childhood.

II.B.2.b.ii. AGENCY CAPACITY

FHSD continues efforts to ensure statewide infrastructure for needs assessment, surveillance, planning, evaluation, systems and policy development, training, and technical assistance. FHSD continues to collaborate with other agencies, provide state support for communities, coordinate with health components of community-based system, and coordinate health services with other services at the community level.

II.B.2.b.iii. MCH WORKFORCE DEVELOPMENT AND CAPACITY

FHSD now has 317 FTE staff, of which 19.85 FTE are Title V funded, and 55 FTE are located on neighbor islands. The Legislature eliminated one vacant FHSD state-funded position (Research Statistician) in 2016.

Kimberly Arakaki began as the MCH Branch Chief in April 2016, bringing her eight years of experience as a branch chief in Developmental Disabilities Division. Recruitment and interviews continue for key FHSD leadership positions (FHSD Chief, vacant since January 2015; Public Health Administrative Officer VI, vacant since October 2014).

Recruit for Epidemiologist II supervisor for the Surveillance, Evaluation, and Epidemiology Unit that oversees 5 programs/federal grants and 9 positions and supports/assures FHSD programs collect, analyze, and utilize data effectively for assessment, program planning, evaluation, quality improvement, and policy development. Recruiting became possible in July 2016 after a legislative change allowed this position to be funded by the Preventive Health and Health Services Block Grant.

II.B.2.c. PARTNERSHIPS, COLLABORATION, AND COORDINATION

Partnership with other DOH agencies:

- FHSD staff and the Office of Planning, Policy, and Program Development are working together on the MCH components of the DOH Strategic Plan and oral health projects.
- CSHNB staff are working with Hazard Evaluation and Emergency Response Office, Indoor Radiological Health Branch, and Public Health Nursing Branch on childhood lead screening and follow-up.

Partnership with other state agencies:

- Department of Human Services (DHS) Med-QUEST Division (Medicaid) is working with CSHNB/Early Intervention Section on roles and processes for coordination between EI care coordinators and QUEST Integration health plan service coordinators for Medicaid-eligible children receiving EI services.
- A new Memorandum of Understanding (June 2016) between DOH and Department of Education (DOE) addresses the transition of children at age 3 years from EI to the DOE special education preschool program.

Public-private partnerships:

- No Wrong Doors: CSHNB is participating in the No Wrong Doors statewide initiative to improve access to long-term services and supports for individuals with disabilities and chronic conditions. This is an initiative of the Governor's Office of Healthcare Transformation, with funding from the Administration for Community Living. Participants include the Executive Office of Aging, DOH Adult Mental Health Division, DOH Developmental Disabilities Division, DHS Med-QUEST Division, and DHS Division of Vocational Rehabilitation, and other agencies.
- Hawaii Maternal and Infant Health Collaborative (HMIHC) is a major partner for FHSD. Established in 2014, it is a public-private partnership to improve birth outcomes and reduce infant mortality. Diverse partners include academia, professional organizations, major health insurers, Hospital Assocation of Hawaii, and state agencies. To impact health issues, HMIHC activities include addressing policy and advocacy, delivery system, consumer education, and payment system. The federal CoIIN to reduce infant mortality is integrated within HMIHC activities and assisted in work on specific strategies among workgroups involved on the pre/interconception, pregnancy and delivery, and infant health and safety periods. Several FHSD members are active participants in the collaborative.
- Legislation: SB2476 (2016), which authorizes language services for children who are deaf, hard of hearing, or deaf-blind and establishes a working group, was passed by the legislature due to strong support from consumers and families. DOH/CSHNB worked with the DOE, Executive Office on Early Learning, and community/family advocates on proposed language for this bill. Bill has been sent to the Governor for approval.
- Legislation: SB2317 (2016) establishes authority and resources to conduct reviews of child and maternal deaths. DOH worked with various stakeholders on proposed language for the bill. Bill has been sent to the Governor for approval.

New need–engaging partners:

In 2010, a new FHSD Chief, Danette Wong Tomiyasu, was hired and FHSD leadership underwent strategic planning. Through an intensive seven-month process, FHSD determined that its primary audience was not families, but instead was partners, stakeholders, and contractors. FHSD did an environmental scan of its contractors and key partners and determined that partnership is a FHSD strength. In general, FHSD recognizes that it cannot do the work alone and its role

as a public health leader is to cultivate, honor, and respect partnerships for improved outcomes for children and families. This led to a revised mission statement, where FHSD is a "progressive leader committed to quality health for the families and communities of Hawaii." FHSD achieves this mission through: quality integrative programs, partner development, operational effectiveness, workforce development. FHSD initially prioritized operational effectiveness and workforce development. In 2015, attention turned towards integration and partnership development. Before becoming good partners to those outside FHSD, a focus was on ensuring colleagues within FHSD recognized the importance of partnership and that the Title V needs assessment was the first step in recognizing that many partners were already working on similar issues and doing their own needs assessments. By selecting Partner Engagement as a State priority, Hawaii will address improving relationships with partners to ensure meaningful outcomes for children and families.

New need–engaging families:

Hawaii's Title V recognizes the importance of family engagement and strives to honor family partners through formal and informal structures. Title V works closely with the Hilopaa Family to Family Health Information Center. In developing the Needs Assessment, priorities were discussed with groups including the Community Children's Councils and Developmental Disabilities Council that included family members. At the 2015 Title V Review, an "ice bucket" challenge was issued to pledge to "collaborate and partner in working to move the needle in Maternal and Child Health, to give all children and their families the best chance to thrive." Part of the challenge was for programs to commit to finding a new family partner. Title V staff attended a training on Focus Groups which contained information on working with families and their critical perspective. Challenges to being responsive partners include technical issues of supporting parent stipends for transportation, child care, and time/effort, as well as practical aspects of constructively using information shared by families. In 2015, the FHSD OPCRH supported the Parent Leadership Training Institute and graduated its first class of parent leaders. However, Title V recognizes that an infrastructure is needed to support ongoing efforts of parent leaders and partners. Hawaii's Directors of Health and Human Services are working with the ASPEN Institute to study the Two-Generation model and are adopting Ohana Nui ("Beloved Family") to approach the generational aspects of engaging with families. Title V recognizes the need to also address multi-generations of families and include them as parent partners. By focusing on Parent Engagement as a State priority, Hawaii will better support parent partners to effectively use opportunities in a changing health care environment.

Five-Year Needs Assessment Summary
(as submitted with the FY 2016 Application/FY 2014 Annual Report)

II.B.1. Process

The Department of Health (DOH) Family Health Services Division (FHSD) conducted a needs assessment that informed FHSD and its state and community partners of the health needs of women, infants and children throughout the state. Findings of the needs assessment assist in identifying Hawaii's Title V maternal and child health (MCH) priority issues.

GOALS, FRAMEWORK, AND METHODOLOGY

The overall goal of the needs assessment was a well-rounded picture of the six population health domains so that priority MCH priority needs could be identified.

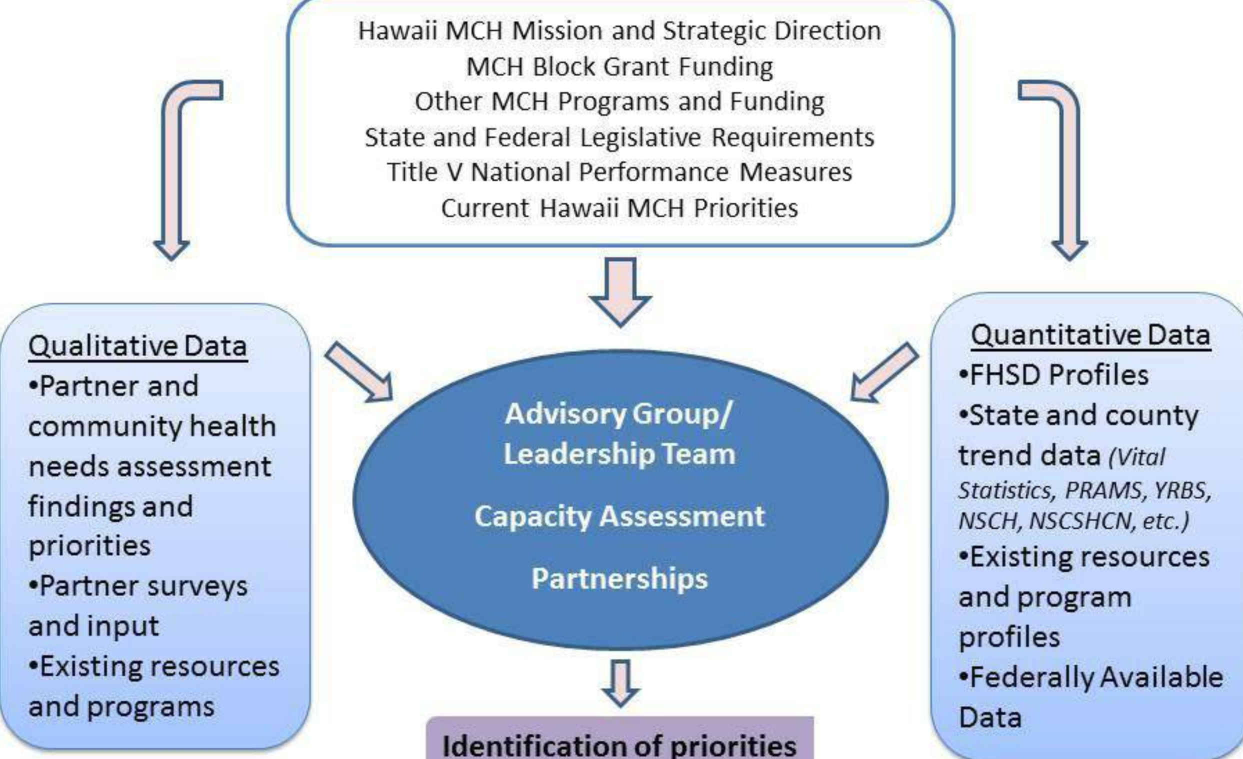
The needs assessment framework included:

- Life course approach: Experiences or exposures during critical periods of an individual's life (e.g., infancy, childhood, adolescence, and childbearing age) can have long-term implications.

- Social determinants of health and health equity:Broad social, economic, and environmental factors must be addressed to promote health and achieving health equity.

- System of health care is family/patient-centered, community-based, and prevention-focused, with early detection and treatment/intervention for those with chronic conditions.

The figure below gives an overview of the needs assessment process.



The FHSD leadership team was responsible for the needs assessment process, identifying priority issues and national performance measures; and/or developing the Title V grant application. The team included: Family Leader (also Director, Hilopaa Family to Family Health Information Center [F2FHIC]); Co-Director, Hawaii MCH Leadership Education in Neurodevelopmental and Related Disabilities [MCH LEND] Program); Medical Director; MCH Epidemiologist assigned by Centers for Disease Control and Prevention (CDC); Oral Health; Early Childhood Comprehensive Systems; MCH Branch; Children with Special Health Needs (CSHN) Branch; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Services Branch; Adolescent Health; and FHSD Coordinators on Neighbor Islands.

STAKEHOLDER INVOLVEMENT

Stakeholder input was obtained in several ways:

- Many FHSD partners have completed or participated in other needs assessment processes within the last several years and have expressed their priorities, strengths, needs and limitations.FHSD felt that recent feedback to other organizations on similar issues and populations should be considered, without overburdening partners by asking them to respond again to similar questions.Therefore other organizations' needs assessments were considered.

- Plans, priorities, position statements, and other documents of various state/community agencies and organizations were examined to identify their MCH issues.

- Trainees in the MCH LEND program, at a FHSD meeting on 11/14/2014, provided presentations on Data Stories and one-page fact sheets on MCH populations and health disparities.

- FHSD Title V priorities were presented at various meetings including American Academy of Pediatrics-Hawaii Chapter leadership, Health and Early Childhood Committee/Hawaii State Council on Developmental Disabilities, Early Childhood Action Strategy/On-track Health and Development Workgroup, University of Hawaii College of Education/Master's Seminar on Issues and Trends in Early Childhood, and Community Children's Council Co-Chair meeting with parent and professionals from all islands.

QUANTITATIVE AND QUALITATIVE METHODS

FHSD completed FHSD Profiles 2014 (see Supporting Documents) as part of the Title V needs assessment. This report provides information on key MCH issues and highlights FHSD programs, their efforts to promote health and improve health outcomes, and partnerships.

Quantitative data on issues were obtained from FHSD Profiles 2014, Federally Available Data, and other sources. Qualitative assessment of FHSD role was done by the FHSD leadership team, based on experience or involvement with various MCH issues. Qualitative assessment of FHSD capacity/resources was done by the FHSD leadership team, based on program responsibilities, populations served, staffing, funding, and mandates. Qualitative assessment of community alignment included identifying MCH issues in needs assessments, plans, and other documents of various state/community agencies and organizations.

DATA SOURCES

Sources of quantitative data included:

- **FHSD Profiles 2014**, which includes data from some sources below.
- **Federally Available Data** (FAD), in the FAD Resource Document and Title V Information System, includes sources below.
- **Behavioral Risk Factor Surveillance System Survey** (BRFSS)
- **National Immunization Survey** (NIS)
- **National Survey of Children's Health** (NSCH)
- **National Survey of Children with Special Health Care Needs** (NSCSHCN)
- **National Vital Statistics System** (NVSS)
- **Office of Health Status Monitoring** (OHSM) – DOH vital statistics
- **Pregnancy Risk Assessment Monitoring System** (PRAMS)
- **State Inpatient Databases** (SID)
- **Youth Risk Behavior Surveillance System** (YRBS)

Sources of qualitative data included:

- **American Academy of Pediatrics (AAP)-Hawaii Chapter, Position Paper:Pediatric Priorities 2015 and**

Beyond. A Family Leader participated in its development.

- **Child and Adolescent Mental Health Division Strategic Plan 2015-2018** (DOH).Public hearings were conducted.

- **Early Childhood Action Strategy, Focus Areas and Objectives,** Governor's Office.The Executive Office on Early Learning, with over 80 private and public partners, identified core areas for a comprehensive and integrated early childhood system.

- **Hawaii Coordinated Chronic Disease Framework**, 2014, DOH Chronic Disease Prevention and Health Promotion Division.This was developed with individuals, organizations, and stakeholders across the state in the public, private, non-profit, and volunteer sectors.

- **Hawaii Injury Prevention Plan 2012-2017**, Injury Prevention Advisory Committee and DOH Injury Prevention and Control Section.Plan was developed with community partners.

- **Hawaii Maternal and Infant Health (MIH) Collaborative**, a public-private partnership to improve birth outcomes and reduce infant mortality, includes American Congress of Obstetricians and Gynecologists, March of Dimes, Healthy Mothers Healthy Babies, Hilopaa F2FHIC, Office of the Governor, FHSD, clinicians, public health planners/providers, insurance, health care administrators, and DOH Office of Planning, Policy and Program Development.

- **Hawaii Physical Activity and Nutrition Plan 2013-2020**.This was developed with public health, community organizations, healthcare professionals, businesses, city planners, school educators and administrators, and other stakeholders.

- **Hawaii State Council on Developmental Disabilities (DD), 2012-2016 State Plan Goals, Objectives, and Activities.**Council members include individuals with DD and family members.

- **Hawaii State Health Improvement Plan** (draft).DOH is the lead in developing this plan for the State of Hawaii as a step toward achieving future public health accreditation.

- **Hawaii State Innovation Model Planning Grant** (Governor's Office) for comprehensive health care system transformation, through shared public-private partnership.

- **Healthy Mothers Healthy Babies Coalition of Hawaii**.Its Perinatal Advocacy Network includes professionals representing various agencies.

- **Hui Kupaa.**This partnership between the State of Hawaii and Hawaii's nonprofit social service providers utilizes a Collective Impact approach to address complex social problems.

- **State of Hawaii Community Health Needs Assessment**, Healthcare Association of Hawaii, 2013. HAH convened seven Hawaii Health Care Forums with diverse stakeholders on three islands centered on local hospitals' top community health priorities.

INTERFACE BETWEEN NEEDS ASSESSMENT, TITLE V PRIORITY ISSUES, AND ACTION PLAN

The Needs Assessment led to identifying Title V priority issues for which the Action Plan was developed. Process:

1. Complete FHSD Profiles 2014 with a broad overview of MCH issues.

2. Select MCH issues for further review, based on six population health domains and link to Title V National Performance Measures, current State priorities, or emerging issues.

3. Needs Assessment with review of MCH issues.

4. Select final Hawaii Title V MCH priority issues based on these criteria:

    a. Data show needs and challenges.Need may be shown by Hawaii rates being worse than the U.S. rate; Hawaii rates for specific groups (e.g., based on insurance, urban/rural residence, racial/ethnic group, etc.) are worse than the state rate; or Hawaii can still improve to reach the best rates of other states.

    b. FHSD is the lead or has a major role and can impact the issue.

    c. FHSD resources (staff, funding) to address the issue.

    d. Community alignment – inclusion of MCH issues in other state/community needs assessments, strategic plans, statewide plans, goals/objectives, or initiatives.

5. Develop the Hawaii Action Plan for the MCH priority issues.

II.B.2. Findings

II.B.2.a. MCH Population Needs

Key findings are presented. Whether an issue met the criteria as a Hawaii Title V priority is indicated.

WOMEN/MATERNAL HEALTH

Reproductive Life Planning/Unintended Pregnancies
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 such as tobacco, alcohol and other drugs.

Data: Hawaii data show a higher rate of unintended pregnancies (52.0% in2012) compared to the national rate (40.0% in 2011). Hawaii data from 2009-2011 show higher estimates of an unintended pregnancy among live births in women under age 20 years (83.4%) and age 20-24 years (62.4%). (Data source: FHSD Profiles/Hawaii PRAMS, CDC/PRAMS)
FHSD Role: Women's and Reproductive Health Section/Family Planning Program (FPP) is the FHSD lead for this area. FPP assures access to affordable birth control and reproductive health services to all individuals of reproductive age.
FHSD Resources: FPP, Perinatal Support Services, Home Visiting Network, and WIC Branch include services that support women during the interconception period, including reducing future unintended pregnancies. FHSD participants on the Hawaii MIH Collaborative include Women's and Reproductive Health Section, WIC Branch, and MCH Epidemiologist.
Community Alignment: State of Hawaii Community Health Needs Assessment identified family planning as one of the 10 highest ranked indicators reflecting local priorities. It noted that family planning is a need for particular groups, primarily low-income families. Hawaii MIH Collaborative's strategic plan includes promoting reproductive life planning. Healthy Mothers Healthy Babies Coalition of Hawaii/Perinatal Advocacy Network includes a focus to improve use of contraception to prevent unintended pregnancy. State Health Improvement Plan (draft) includes reproductive life planning.
Hawaii Title V priority issue? – Met all criteria.

Preventive Health Visits: Preventive health visits help women to adopt or maintain healthy habits and behaviors, detect

early and treat health conditions, plan for a healthy pregnancy, and consider reproductive life planning.

Data: For women with a past year preventive medical visit, the Hawaii rate (62.3%) is lower than the national rate (65.2%). Lower Hawaii rates are associated with household income/poverty <$15,000 (53.2%) and unmarried status (55.8%). (Data source: FAD/BRFSS 2013)

FHSD Role: Women's and Reproductive Health Section will be responsible for this area.

FHSD Resources: Same as for Unintended Pregnancies above.

Community Alignment: Hawaii MIH Collaborative's strategic plan includes promoting preconception health care. State Health Improvement Plan (draft) includes promoting preconception care, reproductive life planning, and healthy behaviors for women during the pre- and inter-conception period.

Hawaii Title V priority issue? – Met all criteria.

Low Risk Cesarean Deliveries

For low-risk pregnancies, cesarean delivery may pose avoidable maternal risks of morbidity and mortality, including hemorrhage, infection, and blood clots.

Data: For cesarean deliveries among low-risk women, the Hawaii rate (19.1%) is less than the national rate (26.8%). (Data source: FAD/NVSS 2013)

FHSD Role: FHSD does not have a lead role, but contributes as part of the Hawaii MIH Collaborative.

FHSD Resources: Limited. FHSD staff participate as part of the Hawaii MIH Collaborative.

Community Alignment: Hawaii MIH Collaborative's strategic plan includes promoting appropriate timing and method of delivery, including reducing early elective deliveries and decreasing primary cesarean deliveries. State Health Improvement Plan (draft) includes reducing elective deliveries and decreasing primary cesarean sections.

Hawaii Title V priority issue? – Did not meet criteria for FHSD role or resources.

Other: FHSD Profiles 2014 provides information on prenatal care, alcohol during pregnancy, prematurity, chlamydia, primary prevention of chronic disease, and violence against women.

PERINATAL/INFANT HEALTH

Infant Mortality

Infant deaths reflect the overall state of maternal and infant health. Risk factors include low birth weight, short gestation, race/ethnicity, access to medical care, sleep positioning, and exposure to smoking.

Data: The infant mortality rate (deaths per 1,000 live births) for Hawaii was 6.1 in 2013, which was slightly below the national rate of 6.4 in 2009. This was an increase from the previous two years, when Hawaii experienced the lowest infant mortality rates ever documented in the state (4.9 in 2011 and 4.7 in 2012). Infant mortality rates for 2011-2013 were higher for maternal age younger than 20 years (11.2), and infants who were black (11.1) or Samoan (10.1). (Data source: FHSD Profiles/OHSM)

FHSD Role: FHSD has a strong role, with responsibility shared among various programs/staff participating as part of the Hawaii MIH Collaborative.

FHSD Resources: Women's and Reproductive Health Section, WIC Branch, and MCH Epidemiologist are active participants of the Hawaii Maternal and Infant Collaborative.

Community Alignment: Hawaii MIH Collaborative's strategic plan includes promoting preconception health care, promoting reproductive life planning, promoting healthy behaviors across the life span, improving access and utilization of appropriate prenatal care, promoting appropriate care for mothers at risk, promoting appropriate timing and method of delivery, promoting healthy behaviors in at-risk populations, and promoting infant well-being.

Hawaii Title V priority issue? – Met all criteria.

BREASTFEEDING: Breastfeeding has been shown to lower the risk of Sudden Infant Death Syndrome. Health advantages of breastfeeding include nutritional, immunological and psychological benefits to both mother and infant as well as economic benefits.

Data: For infants who are ever breastfed, the Hawaii rate (89.5%) is higher than the national rate (79.2%). Lower rates are associated with education/high school graduate (82.4%), and household poverty 100-199% (81.0%).

For infants who are breastfed exclusively through 6 months, the Hawaii rate (26.4%) is higher than the national rate (18.8%). Lower rates are associated with household income-poverty ratio <100% (21.0%), unmarried status (20.7%),

race/ethnicity Hispanic (17.0%) and non-Hispanic multiple race (19.9%), and rural residence (19.6%). (Data source FAD/NIS 2011)

FHSD Role: WIC Branch is the lead for this area and is currently working on this issue.

FHSD Resources: WIC encourages breastfeeding, through information, counseling, incentives, ongoing support including breast pumps, and training WIC breastfeeding peer counselors. FHSD collaborates with Healthy Hawaii Initiative on the Baby-Friendly Hospital Initiative to encourage policies/practices to support exclusive breastfeeding in maternity facilities. Perinatal Support Services contracts with providers ensure comprehensive breastfeeding education and support to high-risk pregnant women at sites in Honolulu, Maui, Molokai and Kauai. Women's and Reproductive Health Section contracts Healthy Mothers Healthy Babies Coalition of Hawaii to administer a statewide information/referral phone line and website for pregnant women and their infants that includes information on breastfeeding and lactation support services. Hawaii Home Visiting Network promotes breastfeeding through health education and information during and after pregnancy.

Community Alignment: Hawaii MIH Collaborative's strategic plan includes promoting healthy behaviors in at-risk populations, including increasing breastfeeding exclusivity. Healthy Mothers Healthy Babies Coalition of Hawaii/Perinatal Advocacy Network includes a focus to increase breastfeeding. Hawaii Physical Activity and Nutrition Plan 2013-2020 includes an objective to increase exclusive breastfeeding through six months by adopting policies and practices that support breastfeeding. State Health Improvement Plan (draft) includes breastfeeding.

Hawaii Title V priority issue? – Met all criteria.

SAFE SLEEP: Sleep-related deaths are the leading cause of infant death after the first month of life. Recommendations to reduce the risk include back (supine) sleep position, safe sleep environment, breastfeeding, and avoiding smoke exposure during pregnancy and after birth.

Data: For infants placed to sleep on the back on their backs, the Hawaii rate (78.1%) is higher than the national rate (74.2%). Lower rates are associated with education/high school graduate (71.4%), Medicaid insurance (70.6%), and maternal age 20-24 years (71.8%). (Data source: FAD/PRAMS 2011)

FHSD Role: Parenting Support Program is the lead for this area and currently works on this issue.

FHSD Resources: Child Death Review Program reviews data on infant sleep-related deaths to identify areas in need of intervention. Parenting Support Program contracted the publishing of "Safe Sleep for all Hawaii's keiki" flyer which is distributed to families of newborns in Hawaii. Hawaii Home Visiting Network for at-risk families with children 0-5 years old promotes education on safe sleep. WIC routinely screens participants for tobacco use and secondhand smoke within the home, informs participants of dangers of tobacco use in the household, and provides community referrals.

Community Alignment: Hawaii MIH Collaborative's strategic plan includes improving safe sleep practices. Department of Human Services Child Care Program is addressing new requirements of the Child Care and Development Block Grant Act of 2014, including establishing health/safety requirements such as safe sleep practices for child care providers. State Health Improvement Plan (draft) includes safe sleep.

Hawaii Title V priority issue? – Met all criteria.

Perinatal Regionalization

American Academy of Pediatrics recommends that very low birthweight infants be born in only Level III or IV Neonatal Intensive Care Units (NICUs) to improve outcomes.

Data: Federally Available Data are not available.

FHSD Role: FHSD does not have a lead role, but contributes as part of the Hawaii MIH Collaborative.

FHSD Resources: Limited.

Community Alignment: Three Level III NICUs on Oahu serve the State of Hawaii – Kapiolani Medical Center for Women and Children (KMCWC), Tripler Army Medical Center, and Kaiser Permanente Medical Center Moanalua. KMCWC services include air transport of neonates from Neighbor Island hospitals to Oahu NICUs. Hawaii MIH Collaborative's strategic plan includes improving access and utilization of appropriate prenatal care, including perinatal regionalization.

Hawaii Title V priority issue? – Did not meet criteria for data, FHSD role or resources.

Other: FHSD Profiles 2014 provides information on newborn metabolic screening, newborn hearing screening, immunizations, school readiness, social emotional health, and health and safety standards in child care.

CHILD HEALTH

Developmental Screening

Screening is important for the early identification of developmental concerns and appropriate follow-up, including monitoring or referrals to early intervention or special education services.

Data: For children age 10-71 months receiving a developmental screening using a parent-completed screening tool, the Hawaii rate (38.9%) is higher than the national rate (30.8%). The Hawaii rate is lower than five other states (range 40.8 to 58.0%). (Data source: FAD/NSCH 2011/12)

FHSD Role: Early Childhood Comprehensive Systems (ECCS) Coordinator is the FHSD lead for this area and the co-lead for the Early Childhood Action Strategy/On-track Health and Development.

FHSD Resources: ECCS grant utilizes a public-private partnership model to build comprehensive developmental screening activities in Hawaii. Developmental screening is provided by the Hawaii Home Visiting Network. FHSD contracts for community health centers encourage developmental screening as part of well-child visits. Children with developmental concerns may be referred for DOH Early Intervention services for children age 0-3 years, as mandated by Part C of Individuals with Disabilities Education Act.

Community Alignment: AAP-Hawaii Chapter priorities for 2015 and beyond include developmental screening and psychosocial/behavioral assessment, using validated screening tools, beginning at infancy through the early elementary school years. Early Childhood Action Strategy/On-track Health and Development includes objectives to coordinate with partners a package of comprehensive screenings for early detection; create a framework for a screening-referral-utilization of services feedback loop within the medical home model; and establish an early childhood tracking system to monitor health and development. Hui Kupaa's Early Childhood Workgroup is focusing on early childhood screening (development, vision, and hearing) in two communities on Oahu. Hawaii State Council on Developmental Disabilities 2012-2016 State Plan includes an objective to partner with pediatric providers and agencies to assure access to developmental screenings.

Hawaii Title V priority issue? – Met all criteria.

Child Abuse and Neglect Prevention

Child maltreatment results in immediate physical or emotional harm or threat of harm to a child.
Long-term, victims of abuse are more likely to experience problems such as drug abuse, delinquency, teen pregnancy, mental health problems and abusive behavior.

Data: The Hawaii rate of confirmed cases of child abuse and neglect per 1000 children age 0-5 years is 6.2 in 2014, unchanged from 2013. No national comparative data is available. (Data source: University of Hawaii Manoa/Center on the Family, Department of Human Services, US Census Bureau)

FHSD Role: Family Support and Violence Prevention Section is the lead for this area and is currently working on this issue.

FHSD Resources: Maternal Infant Early Childhood Home Visiting grant provides funding for the Hawaii Home Visiting Network for at-risk families with children age 0-5 years. MCH Branch is the public sector partner for the Hawaii Children's Trust Fund, which is a public/private partnership to support family strengthening programs aimed at preventing child abuse and neglect. MCH Branch administers a federal Community-Based Child Abuse Prevention grant to support community-based efforts to prevent child abuse and neglect. Parenting Support Program contracts a Parent Line to provide informal counseling and referrals and address questions about child development and behavior, family issues, and community resources through various publications.

Community Alignment: Early Childhood Action Strategy includes Nurturing and Safe Families, which has objectives to identify family strengthening supports and services, develop family strengthening core competencies and trainings for early childhood practitioners, and advance family strengthening public awareness and community engagement. Child Care and Development Block Grant, administered by Department of Human Services, has health and safety requirements (including prevention of shaken baby syndrome and abusive head trauma) for child care providers. State Health Improvement Plan (draft) includes Child Abuse and Neglect Prevention.

Hawaii Title V priority issue? – Met all criteria.

INJURIES: Injuries are the leading cause of death among children. Non-fatal injuries due to child abuse and neglect may result in hospitalization.

Data: For children ages 0-9 years for hospitalization for non-fatal injury, the Hawaii rate (149.1 per 100,000) is lower

than the national rate (166.4). Higher Hawaii rates are associated with age <1 year (182.3) and 1-4 years (168.9), race/ethnicity non-Hispanic Asian/Pacific Islander (300.3) and Non-Hispanic White (178.5), and males (161.6).
For adolescents age 10-19 years for hospitalization for non-fatal injury, the Hawaii rate (212.4) is lower than the national rate (249.9). Higher Hawaii rates are associated with age 15-19 years (290.8), race/ethnicity non-Hispanic Asian/Pacific Islander (323.6) and non-Hispanic white (382.1), and males (272.5). (Data source: FAD/SID 2012)
FHSD Role: Family Support and Violence Prevention Section has a role related to non-fatal injuries due to child abuse and neglect that result in hospitalization.
FHSD Resources: See resources for Child Abuse and Neglect Prevention.
Community Alignment: DOH Injury Prevention and Control Section is the lead agency for injury prevention throughout the state for all age groups. Hawaii Injury Prevention Plan, 2012-2017, includes recommendations for violence and abuse prevention.
Hawaii Title V priority issue? – Met all criteria.

Physical Activity

Regular physical activity is essential in improving the health and quality of life for children and adolescents. It can reduce the risks for cardiovascular disease, hypertension, type 2 diabetes, and osteoporosis later in life.
Data: For children age 6-11 years with physical activity at least 60 minutes per day, the Hawaii rate (39.2%) is higher than the national rate (35.6%). For adolescents age 12-17 years, the Hawaii rate (18.3%) is lower than the national rate (20.5%). (Source: FAD/NSCH 2011/12)
FHSD Role: FHSD does not have a lead role, but works on this issue as part of early childhood and adolescent wellness.
FHSD Resources: Limited. ECCS Coordinator is co-lead for the Early Childhood Action Strategy on On-track Health and Development workgroup, which is developing Early Childhood Health and Wellness Guidelines which include physical activity. The Adolescent Coordinator is the lead for adolescent well-being.
Community Alignment: DOH Chronic Disease Prevention and Health Promotion Division is the lead for Physical Activity and Nutrition (Hawaii Health Initiative). Hawaii Physical Activity and Nutrition Plan 2013-2020 includes objectives regarding comprehensive Health and Physical Education in Department of Education (DOE) schools, and includes physical activity in child care license requirements and wellness guidelines. Hawaii Coordinated Chronic Disease Framework has an objective that educational settings establish comprehensive policies and environments that include supporting daily physical activity for all students.
Hawaii Title V priority issue? – Did not meet criteria for FHSD role or resources.

Other: FHSD Profiles 2014 provides information on child overweight/obesity.

ADOLESCENT HEALTH

Adolescent Well-Visit

Preventive health visits help adolescents adopt or maintain healthy habits and behaviors, manage their health and health care, manage chronic conditions, and plan their transition to adult health care.
Data: For adolescents age 12-17 years with a preventive medical visit in the past year, the Hawaii rate (82.2%) is similar to the national rate (81.7%). Lower Hawaii rates are associated with birth outside U.S. (74.7%) and rural residence (75.9%). (Data source: FAD/NSCH 2011/12)
FHSD Role: The Adolescent Coordinator is the lead on this issue.
FHSD Resources: Children and Youth with Special Health Needs Section will work with the Adolescent Coordinator on this area, as improving the rates for adolescent well-visits may also impact rates for transition to adult health care.
Community Alignment: AAP-Hawaii Chapter priorities for 2015 and beyond include adolescent well care visits with mental health screening annually from age 11 to 21 years.
Hawaii Title V priority issue? – Met all criteria.

Bullying

Bullying experiences are associated with behavioral and emotional problems for both those who bully or are victims of bullying. Problems may continue into adulthood and may have long-term impact.
Data: For adolescents age 12-17 years who are bullied or who bully others, FAD/NSCH 2011/12 data show that the

Hawaii rate (15.4%) was comparable to the national rate (14.2%). The FAD/YRBSS 2013 Hawaii rate (25.8%) was also comparable to the national rate (25.2%).

FHSD Role: Limited. However, FHSD works on this issue as part of adolescent wellness.

FHSD Resources: Limited.

Community Alignment: DOE is working to reduce bullying and cyberbullying in various ways including: implementing school-wide positive behavior practices; anti-bullying program; community partnerships; identifying, monitoring, and tracking student concerns; and supporting victims and bullies to address ongoing conditions. The 2015 State Legislature had several bills on anti-bullying efforts.

Hawaii Title V priority issue? – Did not meet criteria for FHSD role or resources.

Other: FHSD Profiles 2014 provides information on teen pregnancy/births.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Transition to Adult Health Care

Health and health care are major barriers to making successful transitions. Youth with special health care needs, compared to those without special health care needs, are less likely to complete high school, attend college, or be employed.

Data: For adolescents with special health care needs who received services necessary to make transitions to adult health care, the Hawaii rate (37.3%) is lower than the national rate (40.0%). Hawaii rates are lower for males (33.3%). (Source: FAD/NSCSHCN 2009/10)

FHSD Role: Children and Youth with Special Health Needs Section (CYSHNS) currently leads program effects related to transition (e.g., quality improvement) and has leadership roles in planning transition fairs with state/community partners.

FHSD Resources: CYSHNS staff on Oahu and the Neighbor Islands of Hawaii, Maui, and Kauai are involved in transition activities. CYSHNS staff will work with the Adolescent Coordinator on the issue of adolescent well-visits, since it may impact the issue of transition to adult health care. Genomics Section Supervisor is the lead for the Western States Genetic Services Collaborative which includes a priority to support transition from pediatric to adult services.

Community Alignment: AAP-Hawaii Chapter priorities for 2015 and beyond include transition of adolescents to adult care with a focus on youth with special health care needs. Hilopaa F2FHIC provides education and developed materials to support the transition to adult health care. Transition fair planning has involved CYSHNS, Community Children's Council Office, DOH/Developmental Disabilities Division, Hawaii MCH LEND Program, Hawaii State Council on Developmental Disabilities, DOE, Hilopaa F2FHIC, Special Parent Information Network, and other agencies/organizations. DOH Child and Adolescent Mental Health Division Strategic Plan 2015-2018 includes an objective to collaborate with partner state agencies to develop and implement a plan to improve the Hawaii system of care to address the needs of transition-age youth with mental health challenges; this issue was raised during public hearings. Hawaii State Council on Developmental Disabilities 2012-2016 State Plan includes a goal about preparing students at all educational levels for the transition from high school to adult life including employment, self-employment, and/or post-secondary education and training.

Hawaii Title V priority issue? – Met all criteria.

Medical Home

Children with medical homes are more like to receive preventive health care, have fewer hospitalizations for preventable conditions, and have early diagnosis for chronic conditions/special health care needs.

Data: For children with a medical home, the Hawaii rate (57.4%) is higher than the national rate (54.4%). The Hawaii medical home rate for children with special health care needs (43.3%) is lower than the rate for children without special health care needs (60.4%). (Data source: NSCH 2011/12)

FHSD Role: Children and Youth with Special Health Needs Section is not involved in medical home practice changes for primary care providers. However, CYSHNS supports medical homes by working to increase access to services, such as legislative mandates for insurance coverage for orthodontic services for children with orofacial conditions or hearing aids for children with hearing loss. CYSHNS also assists families with service coordination, social work, nutrition services, financial assistance for medical specialty services, and pediatric clinics on the Neighbor Islands where services are not available.

FHSD Resources: FHSD resources are program-specific. Newborn Metabolic Screening and Newborn Hearing Screening Programs support the medical home by helping to identify newborns who require follow-up and coordination

of referrals and services. Early Intervention Section invites the child's medical home providers to Individual Family Support Plan meetings. Genetics Program supports the medical home by increasing access to genetic services in the community, offering outreach clinics to Neighbor Islands and providing telegenetics activities.

Community Alignment: The medical home concept for children is promoted by AAP-Hawaii Chapter and University of Hawaii School of Medicine/Department of Pediatrics. AAP-Hawaii Chapter, with Hilopaa F2FHIC, collaborated with the State's largest insurance payer to develop a pediatric patient-centered medical home (PCMH) model, which provides enhanced payments to physicians who improve quality of care. The largest insurance payer adopted the PCMH model for primary care providers as its value-based health care initiative. Hawaii Primary Care Association facilitates continuous quality improvement programs in Hawaii's community health center network, including the development of PCMH.

Hawaii Title V priority issue? – Did not meet criteria for FHSD resources.

Other: FHSD Profiles 2014 provides information on family partnership, adequate health insurance, early screening and intervention, and community-based services.

CROSS-CUTTING OR LIFE COURSE

Oral Health

Limited access to preventive oral health care increases the risk for oral diseases. Without treatment, dental decay can cause pain and infection that can compromise a child's ability to eat, school attendance, and ability to concentrate and learn in the classroom.

Data: For women who had a dental visit during pregnancy, the Hawaii rate (42.5%) is lower than the national rate (50.3%). Lower Hawaii rates are associated with education/high school graduate (30.9%), Medicaid insurance (22.2%), unmarried status (29.0%), maternal age 20-24 years (29.3%), race/ethnicity Hispanic (34.3%) and non-Hispanic Native Hawaiian/Other Pacific Islander (33.9%) (Data source: FAD/PRAMS, 2012).

For children age 1-17 years who had a preventive dental visit in the past year, the Hawaii rate (83.1%) is higher than the national rate (77.2%). Lower Hawaii rates are associated with children age 1-5 years (69.9%), education/high school graduate (74.8%), Medicaid insurance (75.7%), household income-poverty ratio <100% (69.4%), and unmarried status (74.8%). (Data source: FAD/NSCH 2011/12)

FHSD Role: Oral Health Program is responsible for statewide oral health surveillance, planning, and prevention.

FHSD Resources: FHSD Oral Health Program, MCH Epidemiologist, Office of Primary Care and Rural Health, and WIC Branch, with other state/community partners.

Community Alignment: State of Hawaii Community Health Needs Assessment notes that it is important that Hawaii residents have access to and utilize preventive dental care, and have insurance coverage. The Governor's Office received a second State Innovation Model (SIM) planning grant in February 2015 that includes a focus on improving oral health and access to preventive care for adults and children on Medicaid. The planning process involved over 100 stakeholders. The SIM Oral Health Committee is addressing strategies for the prevention of dental caries for children and improved access to dental care. Hawaii State Council on Developmental Disabilities 2012-2016 State Plan includes a goal that people with intellectual and developmental disabilities will have access to physical and mental health and medical and dental care, and an objective is to increase the number of dentists who serve the Intellectual and Developmental Disabilities population.

Hawaii Title V priority issue? – Met all criteria.

Access to Services through Telehealth

Increasing the use of telehealth by DOH programs may provide greater access to services for families and providers, while saving time and money.

Data: For children age 0-17 years who received or needed specialist care and who had some problem getting specialist care, the Hawaii rate (5.7%) is lower than the national rate (6.4%). Hawaii rates show that children with special health care needs (CSHCN) have more difficulty accessing specialist care (17.3%) compared with non-CSHCN (3.3%). (Data source: NSCH 2011/12)

FHSD Role: Genomics Section is the FHSD lead. Genetics Program has been providing telegenetics services on Neighbor Islands.

FHSD Resources: FHSD staff can work with University of Hawaii and Pacific Basin Telehealth Resource Center to

maximize resources (broadband connections, equipment, training, technical assistance) available and apply for additional funding if needed. Policies and procedures for implementing HIPAA compliance and evaluation methods are already available for telehealth activities. Early Intervention Section is interested in providing tele-early intervention services.

Community Alignment: State of Hawaii Community Health Needs Assessment notes that fewer services are available in rural parts of Oahu and Neighbor Islands, and that many specialized services are not available on each island, requiring costly air transportation to receive needed care. Hawaii State Council on Developmental Disabilities 2012-2016 State Plan includes an activity to pursue statewide telemedicine opportunities. The legislature supports telehealth as evidenced by Act 159 (2014) which mandated reimbursement parity for face-to-face and telehealth visits provided by health care providers. In Genetic Program surveys of Neighbor Island families receiving genetic services via videoconferencing, 20% families reported that they would not have sought genetic services if telehealth had not been an option.

Hawaii Title V priority issue? – Met all criteria.

Smoking

Smoke during pregnancy may increase the risk for fetal death or low birth weight baby. Children exposed to secondhand smoke in their homes have more ear infections, respiratory illnesses, severe asthma, and other medical needs.

Data: FAD data for Hawaii on the percent of women who smoke during pregnancy is not available.

For children who live in households where someone smokes, the Hawaii rate (25.7%) is slightly higher than the national rate (24.1%). (Data source: FAD/NSCH 2011/12)

FHSD Role: FHSD does not have a lead role, but contributes as part of the Hawaii MIH Collaborative.

FHSD Resources: FHSD staff are active participants of the Hawaii MIH Collaborative.

Community Alignment: Hawaii MIH Collaborative's strategic plan includes smoking cessation as part of promoting healthy behaviors across the life span, appropriate care for mothers at risk, and healthy behaviors in at-risk populations. The DOH lead on smoking is the Tobacco Prevention and Education Program which uses prevention and education approaches for activities focusing on youth, second hand smoke, smoking cessation, and disparate populations.

Hawaii Title V priority issue? – Did not meet criteria for FHSD role or resources.

Adequate Insurance Coverage

Inadequately insured children are more likely to delay or forego care, lack a medical home, be less likely to receive needed referrals and care coordination, and receive family-centered care.

Data: For children ages 0-17 years who are adequately insured, the Hawaii rate (81.2%) is higher than the national rate (76.5%). (Data source: FAD/NSCH 2011/2012)

FHSD Role: FHSD is not the lead for this area. However, CSHN Branch programs contribute to adequate insurance coverage in specific areas.

FHSD Resources: Resources are limited to specific areas. Working with community partners, the CYSHNS assisted in legislative efforts to mandate insurance coverage of orthodontic services for children with orofacial conditions, and coverage of hearing aids for individuals with hearing loss. Genetics and Newborn Metabolic Screening Programs work with families and third-party payers on improving the process for coverage and reimbursement of medical formulas and foods. Genetics Program works with genetics specialists and third-party payers to improve the approval process and reimbursement for genetic services.

Community Alignment: State of Hawaii Community Health Needs Assessment notes that while health insurance in Hawaii is better than the U.S., other access issues include fewer health services in rural parts of Oahu and neighboring islands and that many specialized services are not available on each island.

Hawaii Title V priority issue? – Did not meet criteria for FHSD resources.

Other: FHSD Profiles 2014 provides additional information on health equity, access to health services, and Neighbor Island coordination.

SUMMARY OF HAWAII TITLE V PRIORITY ISSUES

The following issues met the selection criteria and are the final Hawaii Title V priorities:

- Promote reproductive life planning *(related to well woman visits)*
- Reduce infant mortality *(related to promoting breastfeeding and safe sleep practices)*
- Promote early childhood screening and development
- Prevent child abuse and neglect *(related to hospitalization for non-fatal injuries)*
- Promote adolescent well-being *(related to adolescent well-visits)*
- Promote transition to adult health care
- Improve oral health
- Improve access to services through telehealth

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

The Department of Health is a major administrative agency of state government with the Director of Health appointed by and reporting directly to the Governor (Figure 1). DOH has three major administrations, including Health Resources Administration (HRA) (Figure 2). Divisions within HRA include FHSD, which is responsible for the administration of all Title V funding. FHSD has the MCH, CSHN, and WIC Branches (Figure 3 and 3.a).

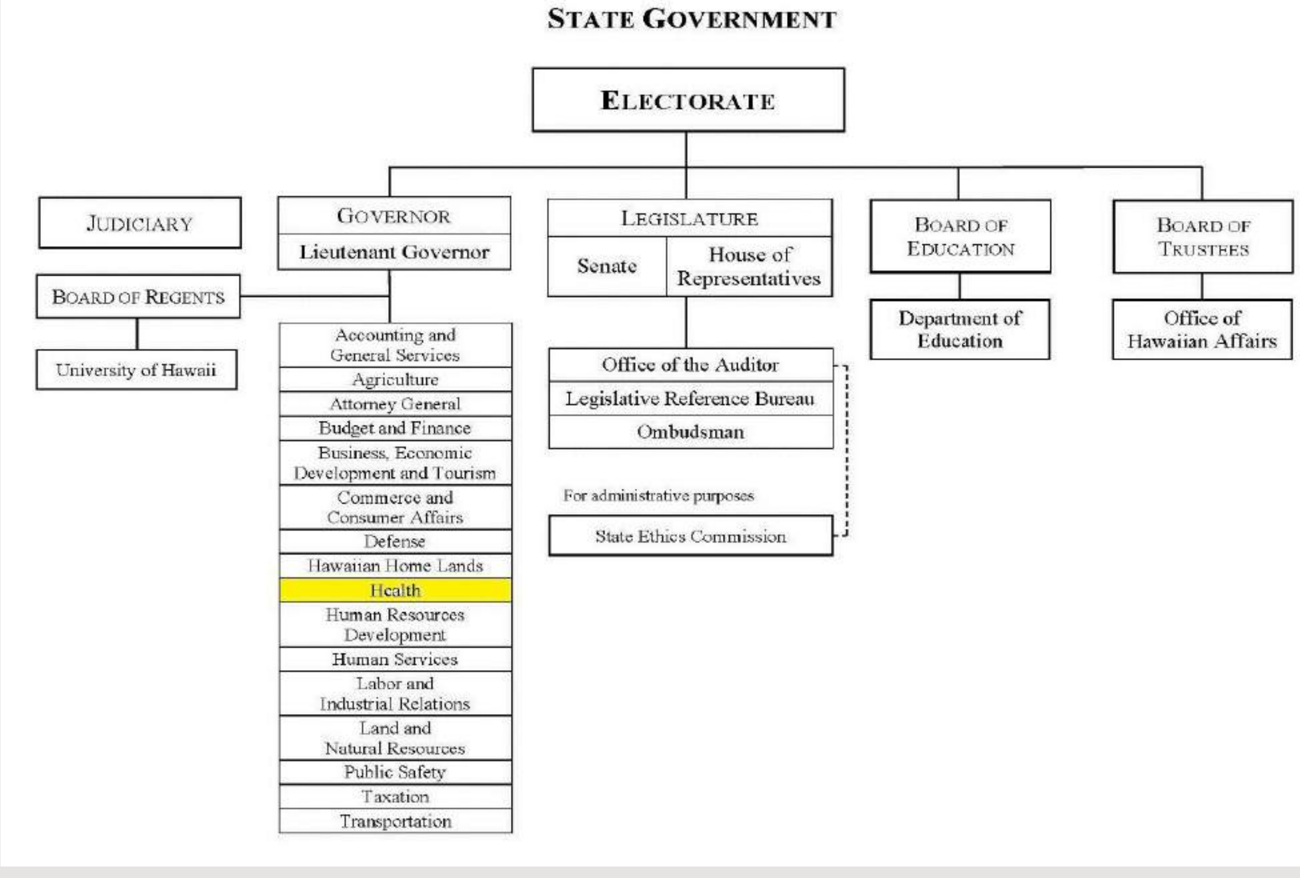


Figure 1

 Created on 7/15/2019 at 7:31 PM

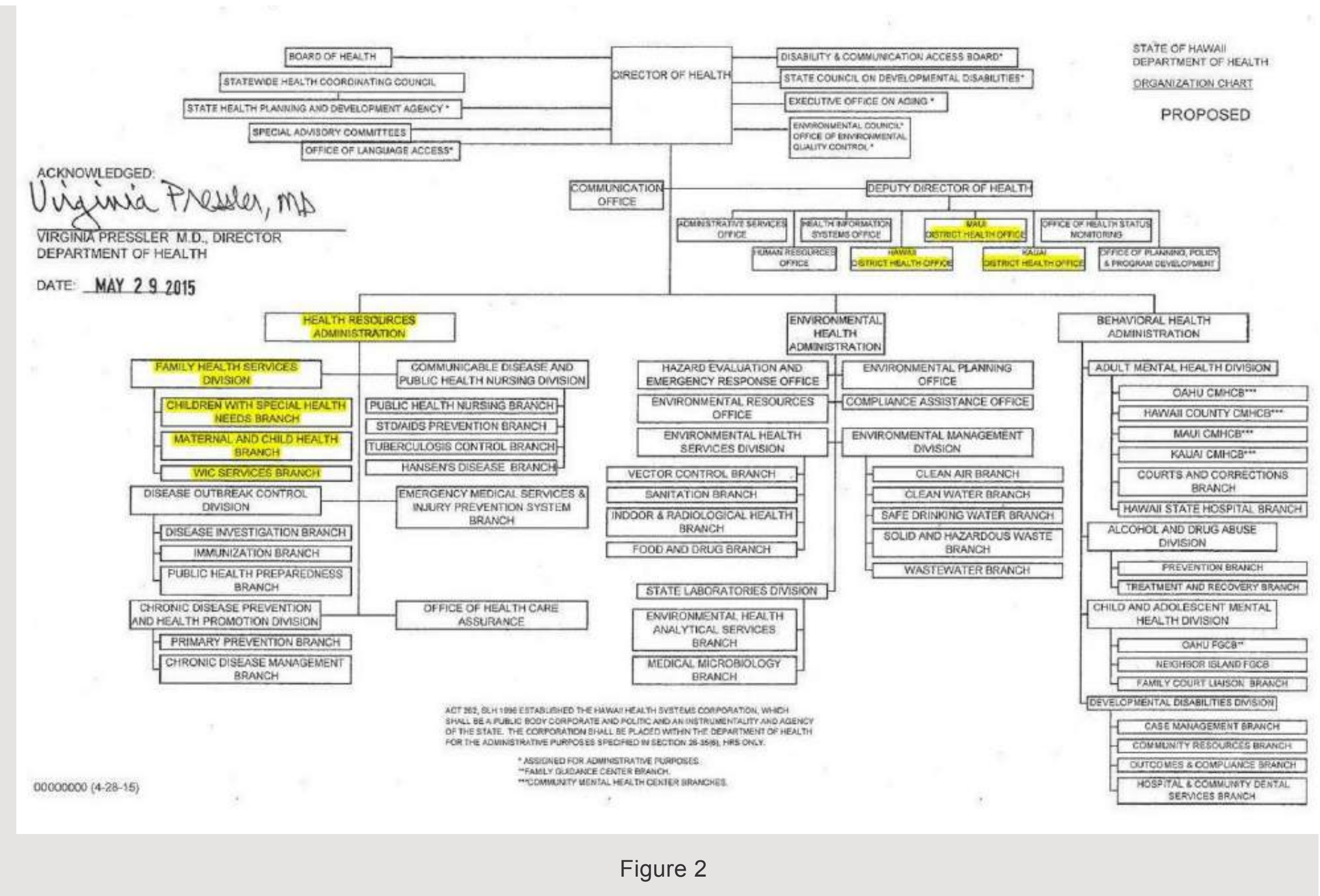


Figure 2

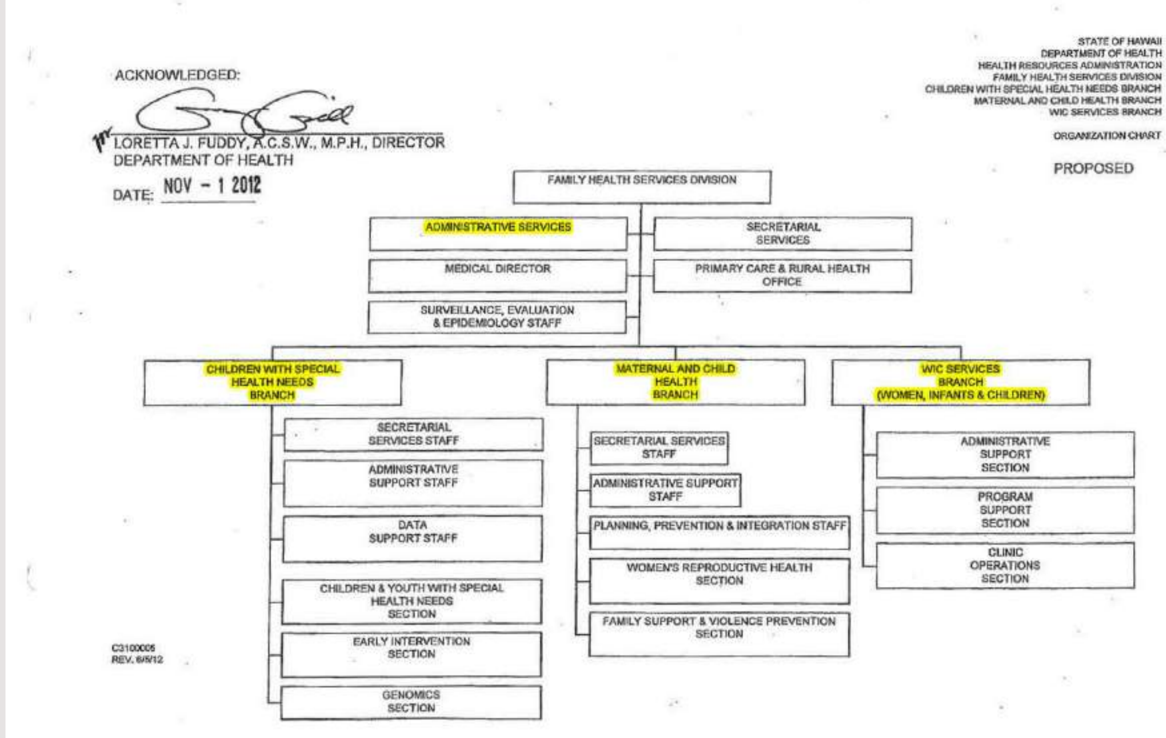


Figure 3

HAWAII TITLE V PROGRAMS
BY ORGANIZATION

DIVISION ADMINISTRATION

- Critical Access Hospitals (Flex)
- Early Childhood Comprehensive Systems
- Fetal Alcohol Spectrum Disorders
- Oral Health
- Pregnancy Risk Assessment Monitoring System
- Primary Care Contracts
- Primary Care Office
- Rural Hospital Subsidy Contracts
- State Office of Rural Health
- State System Development Initiative

MATERNAL AND CHILD HEALTH BRANCH

- Adolescent and Youth
- Child Death Review
- Community Based Child Abuse Prevention
- Domestic Violence
- Family Planning
- Hawaii Children's Trust Fund
- Maternal, Infant, and Early Childhood Home Visiting
- Parenting Support
- Perinatal Support Services
- Sexual Violence Prevention
- Teen Pregnancy Prevention

CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH

- Birth Defects
- Children with Special Health Needs Program
- Early Intervention Services
- Genomics
- Newborn Hearing Screening
- Newborn Metabolic Screening

WOMEN, INFANTS AND CHILDREN SERVICES BRANCH

- Breastfeeding
- WIC

Figure 3.a.

II.B.2.b.ii. Agency Capacity

STATE'S CAPACITY TO PROMOTE AND PROTECT THE HEALTH OF MOTHERS AND CHILDREN, INCLUDING CSHCN

In Hawaii, Title V is considered the "umbrella" for the work of FHSD to improve the health of women, infants, children and adolescents and other vulnerable populations and their families in Hawaii.

FHSD mission is: "A progressive leader committed to quality health for the families and communities in Hawaii." FHSD working principles are: data driven; outcomes, impacts via evaluation; evidence based, best/promising practices; community engagement; systems building, policy development, environmental change; life course approach; and quality improvement.

FHSD programs work to ensure statewide infrastructure for data collection, needs assessment, surveillance, planning and evaluation, systems and policy development, monitoring, provision of training, and technical assistance to assure quality of care.

FHSD is able to address each of the population health domains through its many programs (see figure below).

Family Health Services Division Programs
By Title V Population Health Domains

Women/Maternal Health
Family Planning
Fetal Alcohol Spectrum Disorder*
Hawaii Home Visiting Network*
Parenting Support Program*
Perinatal Support Services*
PRAMS*
WIC Services*
Sexual Violence*

Perinatal/Infant Health
Birth Defects Program
Breastfeeding
Child Death Review
Children&Youth w/ Special Needs*
Early Childhood Comp. Systems*
Early Intervention*
Fetal Alcohol Spectrum Disorder*
Hawaii Home Visiting Network*
Newborn Hearing Screening
Newborn Metabolic Screening
Parenting Support Program*
Perinatal Support Services*
PRAMS*
WIC Services*

Child Health
Child Abuse Prevention
Children&Youth w/ Special Needs*
Early Childhood Comp. Systems*
Early Intervention*
Hawaii Children's Trust Fund
Hawaii Home Visiting Network*
Parenting Support Program*
Sexual Violence*
WIC Services*

Adolescent Health
Adolescent Program
Children&Youth w/ Special Needs*
Parenting Support Program*
Sexual Violence*
Teen Pregnancy Prevention

Children & Youth with Special Health Care Needs
Birth Defects Program*
Children and Youth with Special Health Needs Section*
Early Intervention Services*
Newborn Hearing Screening*
Newborn Metabolic Screening*

Cross-Cutting or Life Course
Critical Access Hospitals
Domestic Violence Prevention
Genetics Program
Hawaii, Maui, and Kauai District Health Offices
Oral Health Program
Primary Care Contracts
Primary Care Office
Rural Hospital Subsidy Contracts
State Office of Rural Health
State System Development Initiative

Preconception Prenatal Early Childhood Childhood Adolescence Adulthood

Lifespan

*Listed in several domains

A Title V purpose is to provide rehabilitation services for blind and disabled individuals under age 16 years receiving benefits under Title XVI (Supplemental Security Income [SSI]), to the extent medical assistance for such services is not provided under title XIX (Medicaid). Children and Youth with Special Health Needs Section (CYSHNS) social workers provide outreach to medically eligible SSI applicants referred by the Disability Determination Services Office/Department of Human Services. Outreach includes information, assistance, and social services for immediate concerns, and referrals to appropriate resources and programs. For SSI children/youth who are eligible for program services, CYSHNS provides service coordination, social work, nutrition services, financial assistance for medical specialty services, and clinics on Neighbor Islands where services are not available.

ENSURING A STATEWIDE SYSTEM OF SERVICES

State program collaboration with other agencies: Collaborations include:

- Increasing data capacity:This is a result of FHSD partnership with the DOH Office of Health Status Monitoring; investing resources into Hawaii Health Survey, PRAMS, and other health surveillance tools; and maximizing use of MCH epidemiologist.WIC, PRAMS and Birth Defects data are included in DOH Data Warehouse.

- Monitoring health through data linkages and sharing:WIC and Early Intervention Section data will be included in the statewide longitudinal data system of the University of Hawaii P-20 Data exchange Partnership.It will link child data from DOH to Hawaii K-12 public school system (Department of Education), higher education (University of Hawaii), and workforce development (Department of Labor and Industrial Relations).

- Informing, educating and empowering through partnerships and public awareness campaigns such as Child Abuse

Neglect Prevention and Child Abuse Prevention, Fetal Alcohol Spectrum Disorders, Women’s Health Month, Children and Youth Month, and Safe Sleep.

- Developing Policies:DOH works with partners to promote legislation.Hawaii Maternal and Infant Health Collaborative is a public-private partnership that includes community non-profit organizations, health care providers, and state agencies to advocate for perinatal needs.

- See “Partnerships, Collaboration, and Coordination” for other FHSD collaborations.

-
State support for communities. Examples include:
- FHSD coordinators in each DHO promote MCH/CSHCN public health activities on Neighbor Islands.

- WIC, family planning, early intervention, and children with special health needs services are statewide, on all islands.Community health centers across the state are contracted to provide primary care services.

- FHSD periodically publishes a State of Hawaii Primary Care Needs Assessment Data Book to assist communities in examining their health care needs.

- Many programs provide outreach and referral through toll-free telephone warm lines, community-based health fairs, and websites with local contact numbers.

- Professional development, training and technical assistance is provided statewide.

-
Coordination with health components of community-based systems. Examples include:
- Contracts with Community Health Centers support access to prenatal care and other medical and dental services at the community level.

- Children and Youth with Special Health Needs Section provides pediatric cardiology, neurology, and nutrition clinics on the islands of Hawaii, Kauai, Maui, and Molokai where services are not available.Eligible children/youth are assisted with air/ground transportation from Neighbor Islands to Oahu pediatric specialty services as needed.

- Genetics Program, with Hawaii Community Genetics geneticists, provides genetic evaluation and counseling to families at Neighbor Island in-person clinics and telehealth clinics via videoconferencing.

-
Coordination of health services with other services at the community level: Examples include:
- DHO Family Health Services Coordinators work with their communities to coordinate health and other services.

- For FHSD contracts with community health centers, providers must respond to a core set of objectives and report on the impact of services within their respective communities.

- CSHN and Early Intervention care coordinators and other staff for State or contracted programs are expected to ensure that program services are coordinated with a child/family’s other services.

II.B.2.b.iii. MCH Workforce Development and Capacity

MCH AND CSHCN WORKFORCE

FHSD targets the three Title V populations: pregnant women, mothers, and infants; children and youth; and children/youth with special health care needs. FHSD has 318 FTE staff, of which 19.85 FTE are Title V funded, and 55 FTE are located on Neighbor Islands.

	Total FTE (all funding sources)	Title V FTE*	Hawaii FTE	Maui FTE	Kauai FTE
FHSD Administration	28.0	3.50	2.0	2.0	2.0
MCH Branch	42.5	11.10	0.5	0	0
CSHN Branch	131.0	5.25	6.0	3.5	3.0
WIC Branch	116.5	0	19.0	11.0	6.0
TOTAL	**318.0**	**19.85**	**27.5**	**16.5**	**11.0**

*Excludes positions that will not be filled due to insufficient Title V funds.

- FAMILY HEALTH SERVICES DIVISION:FHSD Chief position has been vacant since 1/1/15 and is in the hiring process.Former FHSD Chief, Danette Wong Tomiyasu, is now Deputy Director of the Health Resources Administration.Medical Director is Louise Iwaishi, MD, and MCH epidemiologist is Don Hayes, MD, MPH.Division programs include Office of Primary Care and Rural Health, PRAMS, State Systems Development Initiative, Early Childhood Comprehensive Systems, and Fetal Alcohol Spectrum Disorder.

- CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH: Patricia Heu, MD, MPH, pediatrician, has served as the Branch Chief since 1997. Programs include Newborn Hearing Screening, Newborn Metabolic Screening, Children with Special Health Needs, Early Intervention, Genetics, and Birth Defects Programs.

- MATERNAL AND CHILD HEALTH BRANCH: Branch Chief position has been vacant since 3/20/15 and is the hiring process. Programs include Family Strengthening and Violence Prevention, Home Visiting Services, Child Death Review, Reproductive Health Services, Women's Health Clinical and Quality Assurance, and Adolescent Health programs.

- WIC SERVICES BRANCH. Linda Chock, MPH, RD, has served as WIC Director and Branch Chief since 1997. Programs include Breastfeeding.

- DISTRICT HEALTH OFFICES (DHOs): DOH programs on the Neighbor Islands are administered by three DHOs for Hawaii, Maui, and Kauai Counties. Each DHO has a Family Health Services Coordinator responsible for FHSD services (Children with Special Health Needs, Early Intervention, Maternal and Child Health, WIC). Each office may also have other responsibilities and have projects/activities specific for their communities.

- TITLE V FAMILY LEADER: Leolinda Parlin has been active in the needs assessment process and planning of Title V MCH/CSHCN priorities and activities for many years. She is the parent of a young man with special needs; Director, Hilopaa F2FHIC; Co-Director, Hawaii MCH LEND Program; Coordinator, Family Voices of Hawaii; Family Delegate, Association of MCH Programs.

Needs and challenges:

- Vacancies for key leadership positions, with a lengthy hiring process.

- Difficulty in filling Title V funded positions, due to insufficient Title V funding.There has not been an increase in Title V funding to correspond with salary increases.

- Difficulty in requesting new State general funded positions due to State economic concerns.

- Difficulty in filling federal grant funded positions due to a lengthy process.

- FHSD is still adjusting to the loss of a significant number of positions with the Reduction in Force of 2009 and other personnel action, which resulted in the abolishment of 76.75 permanent positions within FHSD (21.0% staffing reduction).

CULTURALLY COMPETENT APPROACHES

Promoting culturally competent approaches in service delivery include:

- Collection and analysis of data by different ethnic groups.FHSD Profiles 2014 includes data by race/ethnicity for infant mortality, preterm births, and adults with no regular primary care provider.PRAMS data have been analyzed by race/ethnicity for perinatal alcohol use, perinatal smoking, breastfeeding, and other areas.

- Diverse ethnic groups are represented by FHSD leaders/staff; State and community leaders and participants for various committees, task forces, and collaboratives; and family representatives.

- FHSD service contracts include a requirement for providers to comply with state and federal laws regarding language access, including linking clients/families with interpreter services if they do not speak English as their primary language and have a limited ability to read, write, speak, or understand the English language.FHSD contracts also require the provision of sign language interpretation when the primary caregiver needs it.

- FHSD staff follow the same state and federal laws regarding language access.

- FHSD staff participate in Office of Language Access conferences and other trainings.

II.B.2.c. Partnerships, Collaboration, and Coordination

FHSD is committed to working collaboratively and in coordination with other MCH-serving organizations.

Other MCH Bureau investments: FHSD grants include: Early Childhood Comprehensive Systems; Maternal, Infant, and Early Childhood Home Visiting; State Systems Development Initiative; Universal Newborn Hearing Screening and Intervention; and Genetics Services Project (Western States Genetic Services Collaborative).

Other HRSA programs: HRSA Primary Care Office, State Offices of Rural Health, Medicare Rural Hospital Flexibility Program, and Small Rural Hospital Improvement Program grants support the work of the Hawaii State Office of Primary Care and Rural Health.

Other federal investments:

- Administration for Children and Families (ACF) provides funds for the MCH Branch’s Community Based Child Abuse Prevention (CBCAP) grants and Personal Responsibility Education Program. FHSD also collaborates on child care issues with the Hawaii Department of Human Services which houses the Child Care Development Block Grant.

- CDC provides funding for Oral Health Program, and PRAMS. FHSD staff collaborate with the CDC Act Early Ambassador (University of Hawaii/Center on Disability Studies). CDC also deploys to FHSD an MCH Epidemiologist position that is paid through Title V.

- U.S. Department of Agriculture provides funding for the WIC Branch.

- U.S. Department of Education/Office of Special Education Programs provides funding under IDEA Part C IDEA for the Early Intervention Section.

  State and local MCH Programs: DOH is a statewide system. DHOs for the Counties of Hawaii, Maui, and Kauai are considered local health departments. DHO Family Health Services Coordinators actively participate on various FHSD committees and initiatives.

  Other programs in State DOH: FHSD partners with many different divisions and branches:

- Public Health Nursing Branch is a partner in many initiatives since many nurses work in the community and are available statewide.
- Chronic Disease Prevention and Health Promotion Division has been instrumental in reducing obesity through the joint promotion of physical activity, breastfeeding, and early childhood health and wellness.
- Immunization Branch works with FHSD to promote the importance of vaccinations and pandemic flu preparedness.
- Office of Health Status Monitoring works with FHSD statisticians and MCH Epidemiologist on use of vital statistics data for program planning and improvement.
- Child and Adolescent Mental Health Division facilitates the Hawaii Interagency State Youth Network of Care, in which the Early Intervention Section participates.
- Developmental Disabilities Division coordinates with CSHN Branch related to services for young children with developmental delays
- Injury Prevention coordinator and staff work with many FHSD programs to address injury prevention.
- Hazard Evaluation and Emergency Response Office collaborates with FHSD staff on lead poisoning prevention.

Other government agencies: FHSD works with other departments including:

- Department of Education (DOE):Hawaii has a single unified public school system serving kindergarten to grade 12.Many FHSD programs work with the DOE on priorities for children (developmental screening, vision screening, and child abuse and neglect), adolescents (wellness), youth with special health care needs (transition to adult life), and life course (oral health).WIC serves with representatives from DOE Office of Hawaii Child Nutrition Programs on various committees. WIC works with DOE School Food Services to coordinate the amount of formula provided by DOE versus WIC. Early Intervention Section works with DOE on the transition of young children from early intervention to DOE preschool special education.
- Department of Human Services (DHS): FHSD representative sits on the DHS Child Care Advisory to discuss the Child Care Development Block grant. Many FHSD staff and Neighbor Island nurses serve on the DHS Child Welfare Advisory committees. FHSD representatives are on the Early Periodic Screening Diagnosis and Treatment (EPSDT) Advisory Committee. A DHS-DOH Memorandum of Agreement provides Medicaid reimbursement to FHSD for early intervention services for QUEST-eligible infants and toddlers who have a developmental delay or biological risk (see Agreement in Section IV).

Public health and health professional educational programs and universities: FHSD partners with the Hawaii Public Health Institute and University of Hawaii/Office of Public Health Studies to promote public health priorities across the state.

Family/consumer partnership and leadership programs:

- Family leaders/partners of diverse ethnicities participate on various councils, committees, and collaboratives, including:
    - Child Abuse Prevention Planning Council
    - Fetal Alcohol Spectrum Disorders Task Force
    - Hawaii Early Intervention Coordinating Council
    - Hawaii Maternal and Infant Health Collaborative
    - Newborn Hearing Screening Advisory Committee
    - Newborn Metabolic Screening Advisory Committee
    - State Systemic Improvement Plan for Part C
    - Western States Genetic Services Collaborative
- A family leader is part of the FHSD leadership team responsible for the Title V needs assessment process, identifying priority issues and performance measures, developing the Title V grant application, and planning for the Title V priorities.
- Family leaders participate as interview panel members for key CSHCN positions.

- Family members provided input to a draft Early Intervention brochure.
- Legislation: HB 174 (Act 213) became law on 7/2/15, with many families present at the bill signing by the Governor. The law requires insurance coverage of medically necessary orthodontic treatment for orofacial anomalies for individuals under age 26 years. Family support of this bill through testimonies at legislative hearings and meetings was critical.

- FHSD Office of Primary Care and Rural Health is working with local partners to pilot the Parent Leadership Training Institute.This civic leadership program is designed to help parents become leaders for children and their communities and expand their capacity as change agents. The first cohort in one community “graduated” in 2015, and the next group in two communities will begin in fall 2015.Graduates were required to attend all 20-week sessions and work on a community-based project based on their personal passion. Several FHSD and DOH programs supported this effort with resources and in-kind support.

Other public and private organizations that serve the MCH population include: American Academy of Pediatrics–Hawaii Chapter, community health centers, Hawaii MCH LEND, Hawaii Dental Association, Hawaii Primary Care Association, Healthy Child Care Hawaii, Healthy Mothers Healthy Babies, Hilopaa F2FHIC, hospitals/birthing facilities, March of Dimes, and many others.

III.D. Financial Narrative

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,156,997	$1,213,952	$2,176,627	$1,998,893
State Funds	$28,911,631	$26,442,167	$29,083,184	$24,722,002
Local Funds	$0	$0	$0	$0
Other Funds	$75,000	$0	$75,000	$47,719
Program Funds	$16,520,311	$12,356,042	$16,745,817	$10,892,484
SubTotal	$47,663,939	$40,640,408	$48,080,628	$37,661,098
Other Federal Funds	$54,186,151	$31,816,371	$55,420,856	$44,210,716
Total	$101,850,090	$72,456,779	$103,501,484	$81,871,814

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,989,226	$1,882,488	$2,394,340	
State Funds	$28,414,686	$27,324,746	$28,350,378	
Local Funds	$0	$0	$0	
Other Funds	$63,078	$0	$0	
Program Funds	$16,422,876	$11,056,301	$13,205,575	
SubTotal	$46,889,866	$40,263,535	$43,950,293	
Other Federal Funds	$49,970,074	$39,143,194	$51,294,329	
Total	$96,859,940	$79,406,729	$95,244,622	

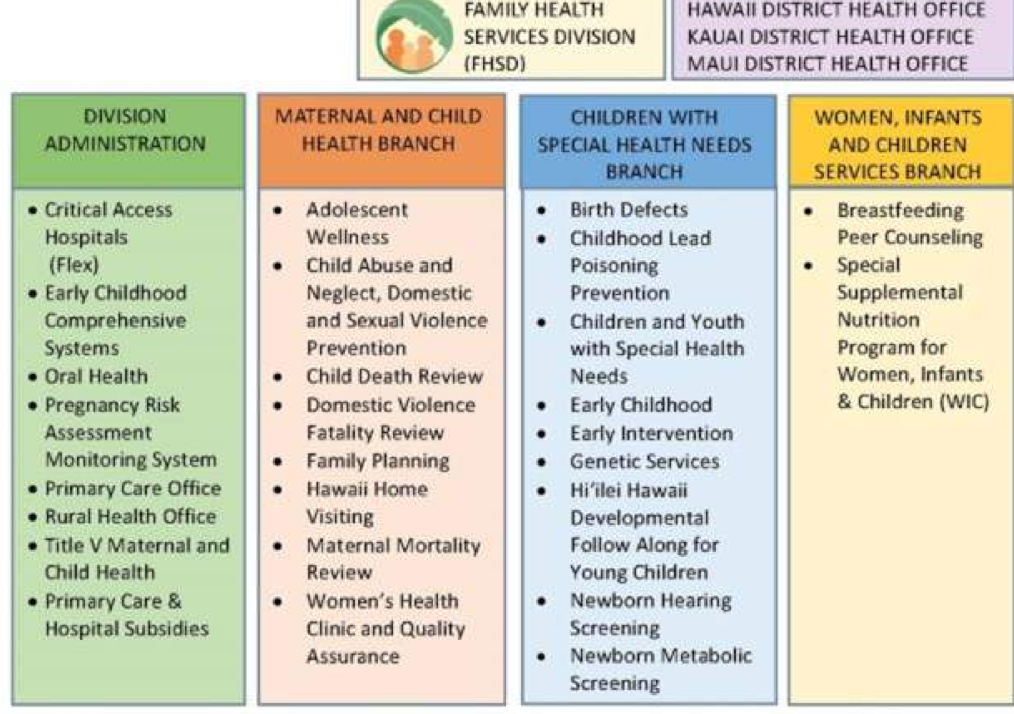
	2020	
	Budgeted	Expended
Federal Allocation	$2,077,106	
State Funds	$31,499,929	
Local Funds	$0	
Other Funds	$203,441	
Program Funds	$13,584,510	
SubTotal	$47,364,986	
Other Federal Funds	$45,765,848	
Total	$93,130,834	

III.D.1. Expenditures

Every day, the Hawaii State Department of Health (DOH), Family Health Services Division (FHSD) strives to make a positive difference in the lives of women, children and families. Consisting of approximately 30 programs, FHSD works to promote and improve the health and well-being of Hawaii's mothers and children (including CSHCN) and their families. This grant application describes how the budget and expenditures align to support FHSD programs, including the Title V priorities, to improve the health of the state's MCH population.

Overview of FHSD Programs

As noted earlier, the Hawaii DOH is the only public health agency in the state. Thus, unlike other states, FHSD must provide all levels of service delivery: direct, enabling, and infrastructure building for all of the counties. One of the largest Divisions in DOH, FHSD's 3 branches–Maternal and Child Health (MCH), Children with Special Health Needs (CSHN), and Women, Infants & Children (WIC) Services; together, addressed this need with a FY 2018 total budget of $96.9M and expenditures of $79.4M. The funds supported the Division's 30 programs (includes 27 programs and 3 neighbor island district health offices) and allowed for the execution of approximately 150 service contracts with community-based organizations throughout the state totaling roughly $36M. The table below lists the FHSD programs by Division and Branch.



The work of the Division is conducted by 337.5 FTE (FY 2018) positions statewide funded by both federal and state funds; 46 FTE are located on the 'neighbor island' counties through county district health offices (DHO) on Kauai, Maui, and Hawaii. Each DHO FHSD program is overseen by a Nurse Manager, who supervises both WIC, CSHN, and Early Intervention Services staff.

Federal Funds. FHSD maintains one of the most diverse funding sources in the DOH, nearly evenly split between federal and state funds. In FY 2018 Federal sources included 22 federal grants totaling $52M (including the Title V Block Grant). A list of federal grants by agency can be found in Form 2 for FY 2018. Note that although only 22 grants are listed, the WIC services' branch administers three Department of Agriculture separate grants for WIC services

breastfeeding support, and data system improvements; however, all three grants are listed under one grant. Similarly, the MIECHV program was funded by two separate federal grants that provided base funding and expansion services. The Title V allocation was $1.99M in FY2018, roughly 3.8% of all federal funds and 2.0% of the total FHSD budget.

Listed below are the federal grants as administered by the Division or Branch. All are HRSA Grants unless indicated otherwise.

Division Unit	Federal Grant
Division	Early Childhood Comprehensive Systems Oral Health (CDC) PRAMS (CDC) Primary Care Office Rural Health State Systems Development Initiative Title V MCH Block Grant Critical Access Hospitals (CMS) Rural Hospital Flexibility Program (CMS) Small Rural Hospital Improvement Program CMS)
MCHB	Abstinence Education Community based Child Abuse Prevention Program (ACF) Family Planning (Title X) Maternal, Infant and Early Childhood Home Visiting Preventive Health & Health Services Block Grant (CDC) Rape Prevention & Education (CDC) Personal Responsibility Education Program (Teen Pregnancy Prevention)
CSHNB	Early Identification & Intervention for Infants/Toddlers (Part C of IDEA) Newborn Hearing Screening & Intervention Genetics Program Zika Surveillance Systems Grant Program (CDC)
WIC	WIC Services (DOA) Breastfeeding Support Data System Improvement

State Funds. FY 2018 state funds budgeted totaled $28.4M which was predominantly state funding for personnel and operations (including funding for direct services). A portion of the state funds includes Program Income (Form 2, Line 6) in FY 2018 amounting to $16.4M. This income is managed through five state 'special funds' which include the following:

- Newborn Metabolic Screening (funded by reimbursements for screening test kits)
- Birth Defects Monitoring (funded with $10 from each birth certificate fee)
- Domestic Violence & Sexual Assault (funded from fees generated from birth, marriage and death certificate fees)
- Community Health Centers (funded through a portion of cigarette taxes)
- State Agency transfer 'U' fund (funds received from other state agencies, such as the Department of Human Services who has contributed to the Child Death Review program).

Clients Served. Form 5a reports on the number of clients receiving direct or enabling services with Title V and state matching funds. The total served is 32,959, broken out as follows:

Pregnant Women: 1,013
Infants 1 < 21 Years of Age: 821
Children 1 through 21 Years of Age: 12,046
Children with Special Health Care Needs: 7,254

Others: 19,079

Form 5b estimates FHSD programs using all funding sources were able to reach:

46% of the Pregnant Women
100% of all Infants
12% of Children 1-21 years of age
15% of Children with Special Health Needs
3% of Others.

Use of Title V Funds. To support the infrastructure needed to administer FHSD programs statewide, Title V funds are used for key staff positions (21.15 FTE out of a total of 337.5 FTE) including an epidemiologist, branch research statisticians, MCH and CSHN program managers, a pediatric medical director, nurses, a nutritionist, an audiologist, contract manager, and general office support. These positions are critical to securing, leveraging, and managing FHSD's statewide service system, its broad array of funding sources, addressing statewide surveillance needs, developing critical statewide partnerships, improving quality to assure services are family-centered, culturally competent, and community based.

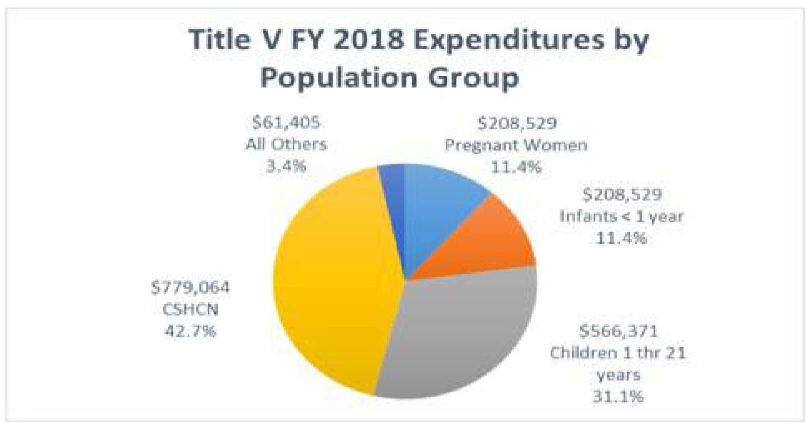
Legislative Requirements Met. The State maintains expenditure and budget documentation for all MCH Block Grant funding allocations for tracking and reporting. Consistent with the requirements in the Title V legislation, expenses are tracked through the state's accounting system, Datamart. The FHSD program undergoes an annual audit required for all State departments.
The Title V legislation also requires a minimum of 30% of block grant funds to be used for preventive and primary care services for children and at least another 30% for services for CSHCN. No more than 10% of the grant may be used for administration. Form 2 reports that Hawaii has met these requirements for FY 2018 expenditures. The table below outlines the FY 2018 budget and expenditures across these categories. Preventive/Primary care for children was 30% of FY 18 Title V expenditures; while CSHCN received 41.3% of Title V funds in the same year. Hawaii is able to keep administrative costs low (3.2%) because DOH waives all indirect costs for the Title V grant.

Category	FY 2018 Budgeted		FY 2018 Expended	
Preventive and Primary Care for Children	$701,684	**35.2%**	$566,371	**30%**
Children with Special Health Care Needs	$713,393	**35.8%**	$779,064	**41.3%**
Title V Administrative Costs	$190,447	**9.6%**	$58,590	**3.2%**

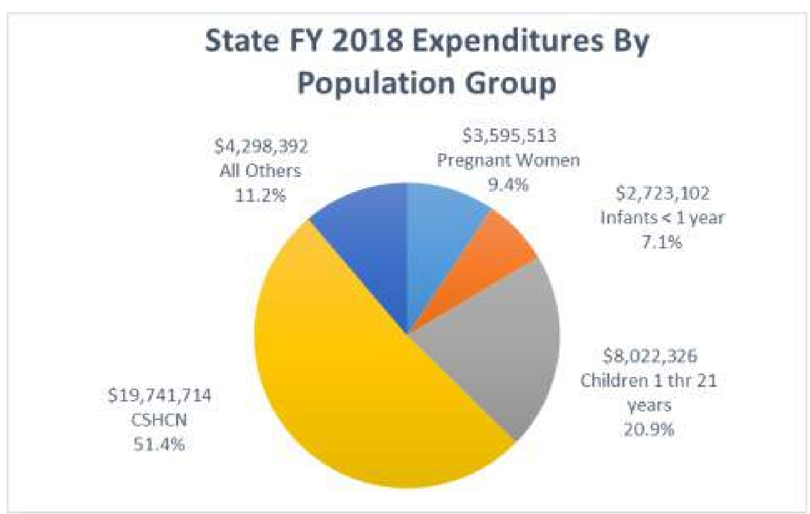
Lastly, the state must meet a maintenance of effort with a state match equal to levels in 1989. With the exponential growth of FHSD since 1989, the FY2018 state expenditure match of $38.4M far exceeds the match requirement.

New Methodology for Reporting. FHSD has relatively new fiscal staff who implemented a new methodology to report Title V budget and expenditures from FY2019 that reflects a more accurate description of funds by Title V reporting categories. In previous years, expenditures (and budgets) were grossly assigned to categories by program budgets/expenditures although programs often serve several population groups and provide several levels of service. Like last year, fiscal staff calculated expenditures for Title V personnel based on program purpose as well as job functions. A detailed spreadsheet was developed to capture this information. Detailed breakouts were also developed for state funded programs and personnel. This new methodology may account for some variances in this year's application. Figures from the old methodology will be phased out and the variances attributed to the old methodology will diminish.

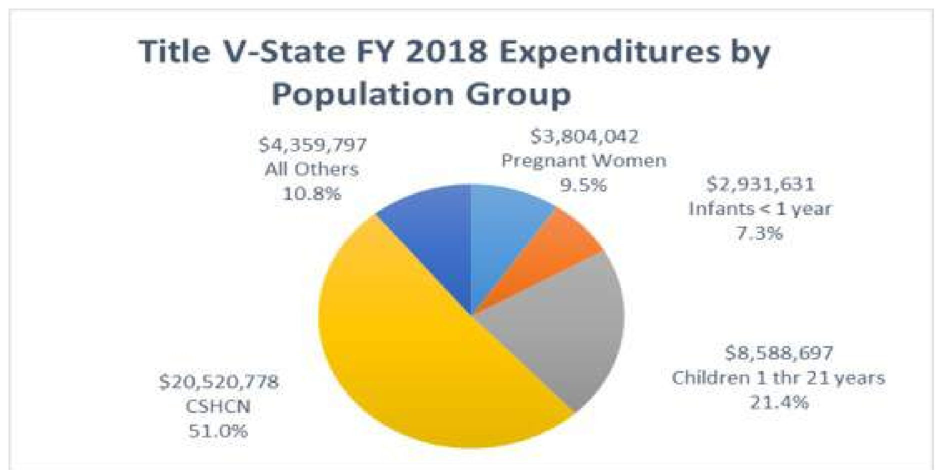
Expenditures by Population Group. The chart below shows how the FY 2018 $1.8M Title V funds were expended to serve the five Title V population groups. The amounts reflect expenditures for Title V funded personnel (21.15 FTE in 2018) to support FHSD programs across the state and $10K for the state MCH hotline. No Title V funds were used for direct services. The breakouts confirm Hawaii expended over 30% for CSHCN (42.7%) and Children 1 through 21 Years (31.1%), followed by Infants < 1 year (11.4%), Pregnant Women (11.4%) and All Others (3.4%).



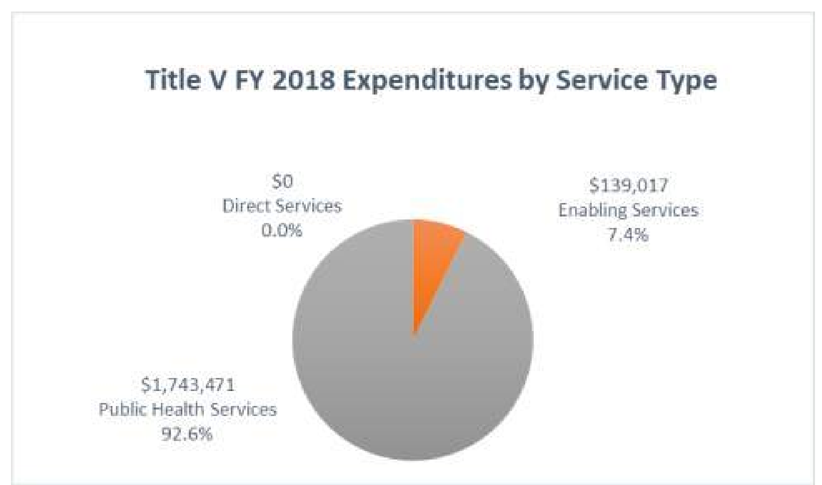
The chart below shows how the FY 2018 $38.4 state matching funds were expended to serve the five Title V population groups as reported on Form 3a, IB, Non-Federal MCH Block Grant. The amounts reflect costs for both personnel and operating (including contracts for service delivery). Over half of FHSD's state funds were dedicated to serve CSHCN (51.4%). The remaining budget was evenly divided by the remaining four populations groups: All Others (general adult population/families), pregnant women, children and infants.



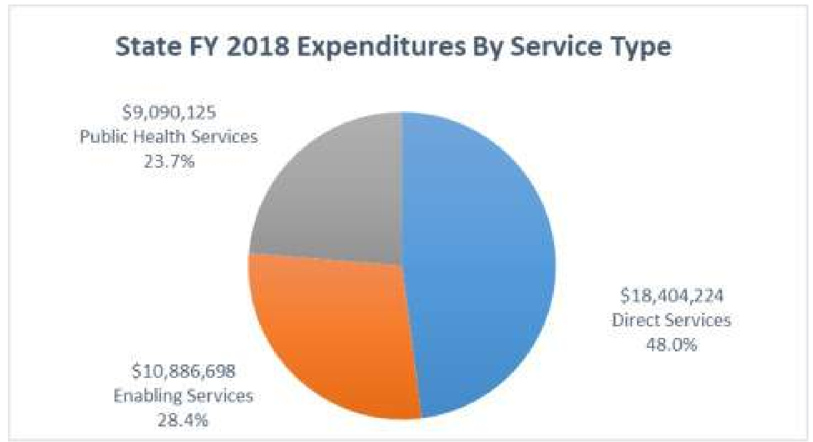
The chart below Illustrates how both Title V and State matching funds in FY 2018 ($40.2M) were expended to serve the five Title V population groups as reported on Form 3a. Over half of FHSD's Federal State MCH Block Grant Partnership funds were dedicated to serve CSHCN (51%). The remaining budget was divided as reported towards the remaining four populations groups: Pregnant Women (9.5%) by followed by All Others (10.8%), Children 1 through 21 Years (21.4%), and Infants < 1 year (7.3%).



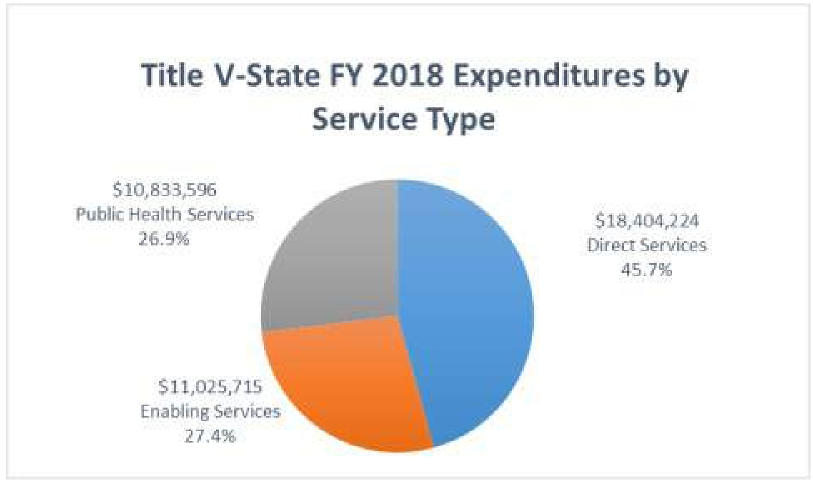
Expenditures by Type of Service. The chart below shows how the FY 2018 $1.8M Title V funds were expended by type of service as defined by the Title V guidance: direct, enabling, and public health services and systems. The amounts reflect expenditures for Title V-funded personnel that support FHSD programs across the state and $10K for the state hotline. The chart shows no Title V funds are used for direct services and nearly all funds are used for Public Health and Systems Building (92.6%) with the remainder used for Enabling Services (7.4%)



The chart below shows how the FY 2018 $38.4M state matching funds were expended by type of service as reported on Form 3b, IIB, Non-Federal MCH Block Grant. The amounts reflect costs for both personnel and operating (including contracts for service delivery). Services for CSHCN make up about half of all FHSD Direct Services. Direct Services make up 48% of expenditures of Non-Federal funds. The remaining state expenditures were divided between enabling (28.4%) and public health services (23.7%). Hawaii clearly relies of Title V funding to provide infrastructure support for its MCH programs.



The chart below shows how both Title V and State matching funds in FY 2018 ($40.2M) were expended by type of service as reported on Form 3b. About half of FHSD's state funds were dedicated to Direct Services (45.7%). The remaining budget was divided by Public Health Services (26.9%) and Enabling Services (27.4%).



Listed below are the FHSD programs by Service Type. Programs often perform several types of service; however, this table reflects the primary function of the program.

Service Type	Program
Direct	Family Planning Perinatal Support Services Early Intervention* Primary Care Services for Uninsured Children & Youth w/Special Needs*
Enabling	Early Intervention* Children & Youth w/Special Needs* Hawaii Home Visiting Program & Network Breastfeeding Support WIC Services Parenting Support Program Sexual Violence Prevention Teen Pregnancy Prevention
Public Health Services & Systems	PRAMS Birth Defects Monitoring Newborn Hearing Screening Newborn Metabolic Screening Child, Maternal, Domestic Violence Fatality Review Early Childhood Comp Systems Child Abuse Prevention Childhood Lead Poisoning Prevention Hawaii Children's Trust Fund Adolescent Health Program Domestic Violence Prevention Oral Health Program Primary Care Office Office of Rural Health Critical Access & Small Rural Hospitals program

Significant Variations – Form 2 and Form 3 (Fiscal Year 2018) - Expenditures

Form 2, Item 1A. Earmark for Preventive and Primary Care for Children. The amount budgeted in this category for fiscal year 2018 was $701,684, however the amount actually expended was $566,371, a difference of $135,313. This variance is primarily due to salary and fringe benefit savings from Title V funded vacancies.

Form 2, Item 1C. Title V Administrative Cost. The budgeted amount for this category in fiscal year 2018 was $191,447, and the actual amount expended from the fiscal year 2018 was $58,590, a difference of $131,857. DOH/FHSD budget allocation methodology changed from last year therefore budget allotted for Title V Admin Costs was greater than actual FY18 expenditures. New methodology will align from next fiscal year.
Form 2, Item 5. Other Funds. The budgeted amount for the category “Other Funds” was only $63,078 in fiscal year 2018 but there were no actual expenditures during the reporting period but the expenditures were we made at a later date.

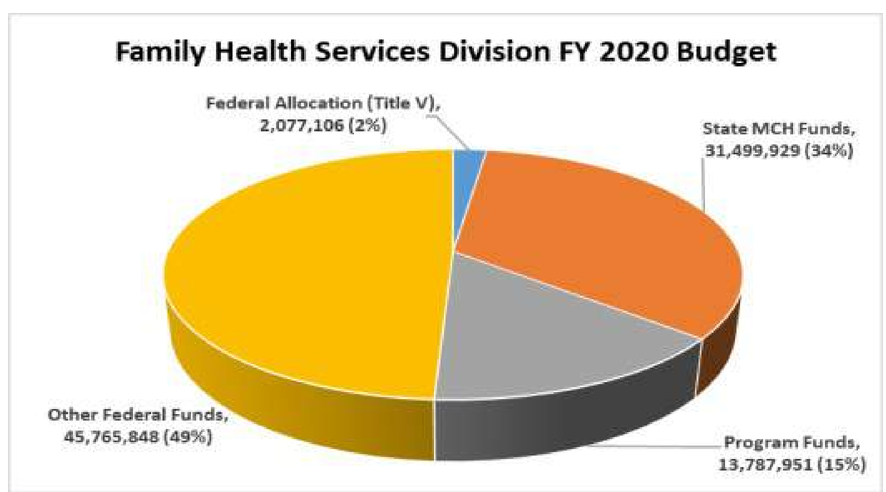
Form 2, Item 6. Program Income. The amount budgeted for this category in fiscal year 2018 was $16,422,876 and the amount actually expended was $11,056,301. The reason for the difference is that the authorized budget ceilings for the Community Health Centers Special Fund, Early Intervention Special Fund, and the Domestic Violence and Sexual Assault Special Fund is higher than the revenues being deposited into these accounts. Annual expenditures are congruent with the revenues being deposited and are not aligned with the authorized budget ceilings for these special fund accounts. FHSD modified budget reporting for Program Income to eliminate this disparity from the FY2020 budget moving forward.

III.D.2. Budget

Every day, the Hawaii State Department of Health (DOH), Family Health Services Division (FHSD) works to improve the health of women, children and families throughout the state. FHSD achieves this work through its Division, Branch, and District Health Offices; 30 programs, nearly 150 service contracts, and in FY 2020 a $93.1M budget.

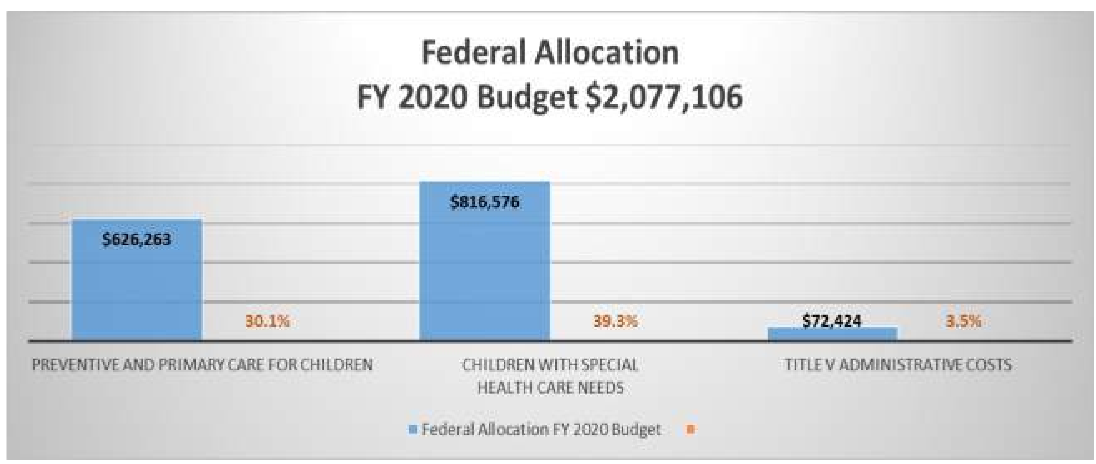
Budget Overview

The chart below provides a quick overview of FHSD's FY2020 Budget as reported on Form 2. The $93.1M FY2020 budget is comprised of nearly $2.1M from Title V; a state match of $47.3M (which includes Program Income/Funds of $13.8M) and Other Federal Funds totaling $45.8M.



Legislative Requirements Met. FHSD is committed to complying with the legislative financial requirements for Title V. The State will maintain expenditure and budget documentation for all MCH Block Grant funding allocations through the state's accounting system, *Datamart*. FHSD will comply with the state annual audit.

Accordingly, FHSD is committed to comply with the legislative financial requirements that a minimum of 30% of Title V funds are utilized for preventive and primary care services for children; at least another 30% for services for CSHCN; and no more than 10% of the grant may be used for administration. For FY2020, Hawaii is allocating $626,263 (30.1%) for Preventive and Primary Care for Children, $816,576 (39.3%) for CSHCN, and $72,424 (3.5%) for Title V Administrative Costs as reported on Form 2, Lines 1. A, B, and C.



Federal Funds. The FY 2020 Other Federal sources includes 18 federal grants totaling $45.8M (without Title V). The Title V allocation is $2.1M, roughly 4.5% of all federal funds and 2.2% of the total FHSD budget.

The overall FHSD federal budget decreased by $5.5M from FY 2019 due to a substantial decrease of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant and the end of the CDC State Oral Disease Prevention Program. A list of the FY 2020 federal grants by agency can be found in Form 2.

As in years past, FHSD relies heavily on federal funding (more than half of total budget). Most grants are utilized to fund positions which manage and administer federally funded programs. In FY2020, consistent with recent trends, most of the federal grant's funding levels are stagnant which creates budget challenges as program costs increase. Operating and personnel costs for federal grants like Title V, Pregnancy Risk Assessment Monitoring System (PRAMS) and Primary Care Office (PCO) are stretched thin from rising operating and personnel costs. For example, consistent increases in collective bargaining agreements for public employees contributes to steady increases in salaries and fringe benefits. The FY2019 indirect cost rate (percentage charged of total salary and fringe) was 22.3%. For programs that rely on grant funding for positions, this can be a substantial expense. As a means of offsetting fixed costs, in some cases, FHSD requested and received a Department waiver of indirect costs. Title V is one of a few grants that the Department allows an annual indirect cost waiver which allows maximum use of the grant dollars for personnel and operating expenses. FHSD also leverages its funding from other grants to support programs and continues to seek state funds. Because costs are rising but funding remains level, as a way of cutting costs, programs have intentionally not filled positions when they are vacated through retirement or attrition or have redescribed and recruited vacated positions from high salary medical professionals (e.g. nurses) to public health program specialists. Finding creative ways to maximize and leverage FHSD federal resources will remain a challenge in FY2020.

State Funds. FY 2020 state general fund budget totals $31.5M which is largely funding for personnel and operations (including funding for direct services). The slight increase
from FY2019 is primarily due to a general fund appropriation increase for the Early Intervention Program. Additional state funds, Program Income, is budgeted at $13.8 in FY 2020 which is a slight increase from FY2019.

Leveraging Resources. FHSD continues to leverage resources through national, state and community partnerships. This is particularly true with the use of Title V funding which supports staffing that provide public health infrastructure services for the Division's programs. The 20.85 Title V funded FTE positions (FY2020) are critical to securing, leveraging, and managing a broad array of funding sources, addressing statewide surveillance needs, developing critical statewide partnerships, improving quality to assure services are family-centered, culturally competent, and community based.

Although, WIC does not receive Title V or state funds, the program benefits from Division's administrative support, epidemiology/data assistance, and technical assistance through collaboration with other FHSD programs.

By also leveraging the MCH Block grant funds through Title V funded personnel, FHSD has and will continue to serve and improve the health and well-being of Hawaii's mothers, children (including children with special needs), and their families. The Title V program efforts and outcomes discussed in the State Action Plan and other sections of this application could not have been achieved without federal MCH Block Grand funding support. All Division and Branch programs will continue to focus on their targeted service population group(s) through contracts and project agreements. FHSD programs are effectively addressing the needs of those we serve and utilizing all capacities to increase awareness and promote family, community, and partnership engagement activities.

Because the DOH is the only public health agency in the state, the absence of local, city, and county health departments in Hawaii requires a disproportionate amount of infrastructure personnel within FHSD to strategically plan and administer resources statewide. The Title V MCH Block Grant provides a critical source of funding for FHSD infrastructure positions. In FY 2017, for example, the Title V funded positions provided critical support to secure new federal and state funding for needed programs and services to reinstitute the Child Death Review, establish a Maternal Mortality Review and receive a new Lead Poisoning Screening and Prevention grant. Services included data analysis, program planning, grant writing and development of policy briefs to obtain the new funding.

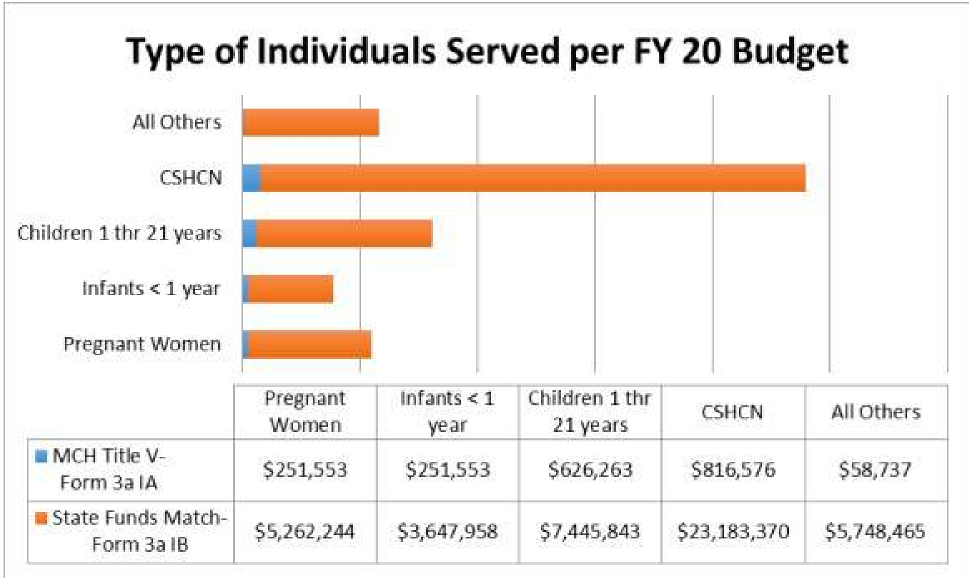
Another example of leveraging Title V funding is found in the distribution of the funding to support key positions within FHSD. The CSHN Branch Chief, also a pediatric M.D., is 75% funded with Title V and 25% Part C funding. She also supervises Hawaii's Part C Early Intervention Services program as part of the CSHN Branch. A portion of both grants are used to support this critical management and medical professional position for FHSD.

The program and staff support for the Title V priorities reflect the diversity in the FHSD budget and the importance of leveraging program funding to support the priorities. FHSD uses both state and federal funding to support the work on the priority issues. The table below summarizes the funding for the program leads dedicated to each Title V priority NPM and SPM and the key FHSD and internal Department of Health funding partners.

Title V Priority	Program Lead (Funding)	Key FHSD/DOH Partnerships
Women's Wellness Visits	Women's Health Section (Title V/Title X)	Title V – Data/Epi Support SSDI – TA for evaluation/planning Family Planning (Title X) PRAMS (CDC) MMR (State) Preventive Health & Health Services Block Grant (PHHSBG) (CDC)
Breastfeeding	WIC Services (USDA)	Title V – Data/Epi Support SSDI – TA for evaluation/planning Early Childhood Comp Systems (HRSA) Perinatal Support program (State)
Safe Sleep	PRAMS (CDC)	Title V – Data/Epi Support SSDI – TA for evaluation/planning Early Childhood Comp Systems (HRSA) Child Death Review (State)
Developmental Screening	Early Childhood Comp Systems (HRSA)	Title V – Data/Epi Support SSDI – TA for evaluation/planning Maui DHO (State) EIS (Part C of IDEA/State) MIECHV (HRSA) Hiilei Developmental Screening (State)
Children's Oral Health	Oral Health Infrastructure grant (CDC)	Title V – Data/Epi Support SSDI – TA for evaluation/planning DOH Developmental Disabilities Dental Program (State) Rural Health (HRSA) PHHSBG (CDC)
Child Abuse & Neglect	Community based Child Abuse Prevention Program (ACF)	Title V – Data/Epi Support SSDI – TA for evaluation/planning MIECHV (HRSA) Rape Prevention & Education (CDC) Early Childhood Comp Systems (HRSA)
Adolescent Wellness Visits	Adolescent Health (Title V)	Title V – Data/Epi Support SSDI – TA for evaluation/planning Personal Responsibility Education Program (ACF)
Transition to Adultcare	CSHN Program (State)	Title V – Data/Epi Support SSDI – TA for evaluation/planning Personal Responsibility Education Program (ACF)
Telehealth	Genetics (HRSA)	Title V – Data/Epi Support Rural Health (HRSA)

The 5-year plan narratives describe the program leads for each priority and their primary sources of funding. Partnerships within FHSD, the DOH, and the community are also described in the plan narratives as vital resources to assure program progress.

Form 3a, *Budget and Expenditure Details by Types of Individuals Served*, *FY2020 Application Budgeted*, demonstrates the federal and non-federal FY2020 application budget. The chart below shows the state and federal breakout of planned resource allocation for each of the five population health domains. The 2020 Title V Federal Allocation budget of $2M and a State Match of $45.3M create a Federal-State Title V Partnership budget of approximately $47.4M. The combined resources form the funding base for strategic collaborations with community providers and partners statewide. Annually, FHSD administers approximately 150 contracts with community organizations that serve Hawaii's MCH population. These vendors include Federally Qualified Health Centers, local hospitals, and private and non-profit providers in urban and rural communities throughout the state. The funds play a key role in building statewide capacity to assure the availability of services for all of Hawaii's families.



	Pregnant Women	Infants < 1 year	Children 1 thr 21 years	CSHCN	All Others
MCH Title V- Form 3a IA	$251,553	$251,553	$626,263	$816,576	$58,737
State Funds Match- Form 3a IB	$5,262,244	$3,647,958	$7,445,843	$23,183,370	$5,748,465

FHSD will continue efforts to ensure statewide infrastructure for needs assessment, surveillance, planning, evaluation, systems/policy development, training, and technical assistance to assure quality of care into the 2020 budget year.

Significant Variations – Form 2 and Form 3 (Fiscal Year 2020) – Budget

Form 2, Item 1A. Preventive and Primary Care for Children. The amount budgeted for this category in the fiscal year 2019 application was $728,721, and the amount budgeted for this category in the fiscal year 2020 application is $626,263. The decrease of $102,458 is primarily due to FHSD budgeting substantially lower for the depature of the CDC-assigned MCH Epidemiologist which occurred December 2019 and the anticipated retirement of the part-time FHSD Pediatric Medical consultant in August 2019. The vacancies account for substantial reductions in FY 2020 since both positions are Medical doctors.

Form 2, Item 5. Other Funds. The category “Other Funds” increased 100% from $0 in the fiscal year 2019 application to $203,441 in the fiscal year 2020 application. In years past, the practice was to include these funds in the “Program Income” category but technically, the funds represent an annual interdepartmental funds transfer from the Department of Human Services and will be reported as “Other Funds” from the FY 2020 budget moving forward.

Form 2, Item 10. Other Federal Funds. The “Other Federal Funds” category decreased by about 12% in fiscal year 2020 from fiscal year 2019. The decrease is largely due to a decrease in MIECHV funding and the loss of the CDC State Oral Disease Prevention Program grant.

Form 3b. IIA. 3. Public Health Services and Systems. The Federal MCH Block Grant budget for Public Health Services and Systems was $2,260,948 in FY19. The FY20 budget for this category decreased by $330,948 to $1,930,000. The decrease in FY20 is due to a change in methodology for calculating this category. The methodology for budgeting this category will remain consistent moving forward.

III.E. Five-Year State Action Plan

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

State: Hawaii

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

In Hawaii, the Family Health Services Division (FHSD) serves as state Title V MCH agency. FHSD is committed to improving the health of women, infants, children including those with special health care needs, and families. FHSD works to promote health and well-being using a life course and multi-generational approach to address social determinants of health and health equity.

The FHSD programs work to ensure statewide infrastructure for data collection, needs assessment, surveillance, planning and evaluation, systems and policy development, and provision of workforce training and technical assistance to assure quality of care.

FHSD is comprised of three branches – Maternal and Child Health, Children with Special Health Needs, and Women, Infants & Children (WIC) Services – and several offices and programs at the Division level.

At the Division-level, FHSD oversees the following programs:

- Title V MCH Block Grant Program
- Early Childhood Comprehensive Systems
- Oral Health Program
- Pregnancy Risk Assessment Monitoring System
- Office of Primary Care and Rural Health including the Primary Care Office (PCO), State Office of Rural Health, the Medicaid Rural Hospital Flexibility Program and the Small Rural Hospital Improvement Program.

The ***Maternal and Child Health Branch*** administers a statewide system of services to reduce health disparities for women, children and families of Hawaii. MCHB programs provide core public health services that establish and maintain public and private partnerships to share information, support program planning, and collaborate on/promote policies to improve outcomes for women, children and families. Services include training and public awareness to high-risk women, adolescents and other disparate populations on family planning, perinatal, and inter-conception care; child and youth wellness; prevention of child abuse and neglect; sexual assault prevention; domestic violence prevention; home visiting services and family supports. Some of the programs include: The Parent Line, Child Death Review, Maternal Mortality Review, the Domestic Violence Fatality Review and over 35 community provider contracts for women's health and family planning services.

The ***Children with Special Health Needs Branch*** works to improve access for children and youth with special health care needs to a coordinated system of family-centered health care services and improve their outcomes. This is addressed through systems development, assessment, assurance, education, collaborative partnerships, and supporting families to meet their health and developmental needs. Programs include:

- Children & Youth with Special Health Needs Section: Children with Special Health Needs, Early Childhood, Hiʻilei Developmental Screening, and Childhood Lead Poisoning Prevention Programs.
- Genomics Section: Genetics, Birth Defects, Newborn Hearing Screening, Newborn Metabolic Screening Programs.
- Early Intervention Section (EIS), with mandated early intervention services provided through 3 state-operated programs and 15 purchase of service programs. The Hawaii Early Intervention Coordinating Council, established under HRS §321-353, advises and assists EIS in the performance of its responsibilities under Part C of the Individuals with Disabilities Education Act (IDEA).

The ***Women, Infants, and Children (WIC)*** Special Supplemental Nutrition Program is a $29M United States

Department of Agriculture (USDA) Food and Nutrition Service (FNS) federally funded short-term intervention program. USDA FNS provides Federal grants to States for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk. The WIC Branch of the Family Health Services Division administers the USDA FNS WIC program for the State of Hawaii.

III.E.2.b. Supportive Administrative Systems and Processes

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

With 337 employees and an annual budget of nearly $97 million, the Family Health Services Division is one of the largest divisions in the Hawaii State Department of Health (DOH). FHSD continues to focus on the four core operational issues identified through a strategic operations planning process in 2013:

- Quality Integrative Programs (to improve cross program collaboration and internal communications)
- Workforce Development
- Partnership Development
- Operational Effectiveness

The new Title V guidance, with its greater emphasis on internal resources, workforce development, and capacity building; is being used to support efforts in the four operational areas. FHSD has always used Title V as an opportunity to build public health capacity for program staff. FHSD staff have varied professional experience and training. Very few of FHSD program staff have formal training in public health. Most have program management experience or subject matter knowledge in their respective program areas.

In 2015, FHSD formalized a Title V Leadership Committee to guide and support the Title V reporting process. The Committee is comprised of program staff leading efforts for the Title V NPM/SPM, FHSD management, neighbor island nurses, Division epidemiology/data staff, and a representative from Hilopa`a Family to Family Information Center (HF2FIC) and MCH LEND faculty. HF2FIC's participation ensures family perspectives are considered in decisions regarding Title V planning. MCH LEND's participation allows Title V to leverage training resources/faculty from the Hawaii LEND program.

The Committee operates as a learning collaborative to support the staff leads with their Title V work and as they develop the narrative reports for the NPM and SPM. The Committee also serves as a unique platform to promote Division wide collaboration. The meetings are often used to share information, resources, identify needs/problems, develop and implement new ideas and innovations. There are few forums to support this type of cross-program discussion.

The past two Title V Review exemplified the type of innovation that typically emerges from the Title V Planning Committee. The Committee agreed the grant presentation in the previous year's Review was too lengthy and decided to create a short 5-minute video to present the Hawaii priorities. The video was well received at the Review and was shared with the MCH Bureau. The video was also highlighted in a 2018 AMCHP conference panel presentation on communications. Other states have contacted Hawaii to utilize the same video software for their Title V reviews.

Based on best practice recommendations shared at the 2018 AMCHP skills-building sessions, FHSD decided to develop logic models to evaluate of the Title V strategies, activities for the national performance measures. Utilizing SSDI grant funds, FHSD contracted with the University of Hawaii Office of Public Health Studies faculty to provide technical assistance with this activity. The process of developing the logic models allowed staff to review program progress, identify short and long-term outcomes, and align strategies with Title V performance and outcome measures. The logic models have been particularly helpful with plan changes to update strategies and strategy measures. The Georgetown University Evidence Center also used the logic models to assist with evaluation of Hawaii strategy measures. The logic models are included in the 5-Year state plan narratives. The logic models will be used in FY 2019 as a tool to engage stakeholders and collect input on Title V activities as part of the needs assessment.

Title V continues to utilize national MCH and AMCHP professional development resources including the MCH Workforce Development Center where Hawaii was part of the first cohort to receive intensive technical assistance (TA) on developmental screening. The use of process maps and continuous quality improvement were tools that the Hawaii team learned and shared with the rest of the Title V staff. Hawaii continues to use national TA from AMCHP learning labs, MCH Bureau Learning labs, as well as recommendations from national consultants particularly for needs assessment. These TA opportunities not only help develop staff capacity, but also provide an opportunity to share Hawaii's issues with other states and national centers.

One of the most promising workforce development initiatives has emerged from FHSD's partnership with the Department of Human Services (DHS) described earlier in the Needs Assessment update. DHS has undertaken a 'Government Transformation' process called *Ohana Nui* (extended family in Hawaiian). To operationalize the transformation process, the DOH and DHS are partnering on a workforce development endeavor led by One Shared Future (OSF), a firm established by the former DHS Director, to support public sector professionals tasked to

implement positive organizational and community change.

OSF recognizes states administer enormous social impact resources, yet public sector professionals are faced with unprecedented challenges including recalcitrant bureaucracies, technological advancement, revenue challenges, dramatic political shifts and uncertainty along with increased need in all areas of community well-being. According to the International Organization for Economic Cooperation and Development (OECD), "Civil service learning has emerged as one of the key factors contributing to an adaptive, responsive, agile and resilient public service in a period marked by the need to establish new and different forms of relationships with citizens. Meeting citizens' expectations in this new environment requires investments in public workforces to build capacity to meet these new challenges."

Working in small cohorts, OSF participants complete an eight-module/64-hour curriculum and apply lessons learned into Springboard Projects that advance their work to impact the culture, conditions, and capacity of their agency. Based on local and global research, OSF utilizes a strengths-based approach (Gallup StrengthsFinder) to support the development of collaborative solutions.

FHSD staff have participated in several OSF cohorts with DHS. OSF graduates have brought an abbreviated version of the series to share with over 50 of the FHSD program staff. In one the Governor was able to provide a brief presentation to thank FHSD staff for their hard work and express the State's commitment to ongoing program improvement and innovation.

Follow-up from the sessions include greater focus on both internal and external communications. A project to design standardized program descriptions will start this summer with assistance from a communications consultant. Also FHSD has prioritized the recruitment of its vacant Information Specialist position. The position description has been expanded to reflect the internal communication capacity building needs of the Division. The revised position describing is pending approval.

Another workforce development effort supported by FSHD is the Hawaii Public Health Training Hui (HPHTH) steering committee. The HPHTH is a group of individuals and organizations established to provide statewide leadership, coordination, and collaboration to meet identified common public health training and technical assistance needs. FHSD serves on the HPHTH steering committee and provides general oversight and direction for the annual training series. Training topics are based on surveys created and disseminated online to employees in both the public and private sectors and guidance from the Western Region Public Health Training Center. The Hui activities are funded by the Health Resources and Services Administration (HRSA) Regional Public Health Training Center Program. In 2018, the HPHTH completed a total of 12 public health trainings on native Hawaiian health assessment, motivational change, collective leadership, mediation, homelessness, opioid/substance use disorder, mental illness/emotional wellbeing, early learning, digital health communications, and youth violence/suicide.

The Title V agency programs also support a substantial amount of training for the MCH workforce statewide. Several federal grants include workforce development as a key strategy/activity including:

- Maternal Infant Early Childhood Home Visiting grant supports monthly training for the Hawaii Home Visiting

Network.

- Early Childhood Comprehensive Systems (ECCS) grant supports training for providers on developmental screening tools and protocols and other infant/toddler health and safety conferences.
- Hawaii Medicare Rural Hospital Flexibility Program grant is used to conduct training on healthcare quality improvement for healthcare professionals and operational and financial performance improvement for Critical Access Hospitals.
- Family Planning shares resources from the National Family Planning Training Centers to local providers via quarterly meetings, webinars, and conference calls.
- The State Office of Rural Health sponsors numerous training projects including the annual Healthcare Workforce Summit.
- A consortium of Title V programs support the Parent Leadership Training Institute.

Many programs broker training resources for DOH staff and community providers on topics including: language access training, drug and alcohol workplace violence, and disaster preparedness. Staff are also often asked to conduct presentations about health topics and Title V programs and services. Examples include:

- Genetics offers webinars on current issues in genetics to providers.
- The Child Abuse and Neglect (CAN) Prevention program conducts presentations on Adverse Childhood Experiences, Trauma-Informed Care, Protective Factors to prevent CAN.
- WIC staff have conducted breastfeeding training seminars to community providers.
- Adolescent Health partnership with community health workers and youth service providers to promote healthy youth development and ado scent wellness visits.

Programs may also sponsor annual conferences for providers to receive updates on research, best practices, and data. Examples include:

- Annual DOH Rape Prevention and Education Sexual Violence Prevention Meeting
- Hawaii State Rural Health Association Annual Conference.
- Early Intervention Stakeholder Conference
- Hawaii Home Visiting Quarterly Meetings
- Hawaii Child Death Review and Maternal Mortality Review Trainings/Summit

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

With the flexibility of the new Title V grant guidance, Hawaii decided to inactive its state performance measure on family engagement, but remains committed to continue efforts increase engagement of families within Title V programs. In this complex and evolving health care environment, FHSD recognizes the importance of parental/consumer involvement and is committed to allocating resources toward the development of a plan that meets current needs and builds Title V staff capacity to focus on family engagement. One strategy FHSD employs is the re-engagement with a key partner—the Hawaii Children's Action Network (HCAN)—to request guidance and support on this endeavor. As a nonprofit organization, HCANs experience and expertise in advocating for children and families is an asset to FHSD. We used findings from an earlier assessment (facilitated by HCAN) to develop a follow-up survey on how FHSD could better incorporate family partnership activities in their work. FHSD is also continuing its collaboration with HCAN on implementing the Parent Leadership Training Institute (PLTI) Hawaii, which is an evidence-based program designed to cultivate parents as leaders and advocates for their children.

Family Engagement Workgroup

In the spring of 2018, FHSD convened a family engagement workgroup to identify potential strategies that support the further integration of families into Division programs. As a result, the workgroup decided to implement a survey designed to:

- Help increase awareness and promote family engagement in all Title V programs,
- Learn from current practices by documenting and sharing the information,
- Help develop methods to increase engagement of families, and
- Identify ways FHSD can support family engagement.

The survey was developed utilizing many of the national family partnership publications/resources promoted by Title V and AMCHP. It also included a definition of family engagement and a series of five multiple choice questions listing the broad spectrum of opportunities and supports for family engagement. The survey was vetted with the Title V management team as well as AMCHP's family engagement staff.

Of those invited to participate in the survey, 87% provided responses (26 surveys completed). Listed below are the individual questions, findings, and comments.

Question 1: What are some of the methods you use to engage families?

Findings: The top three engagement methods identified were advisory committees/taskforces, program outreach, and family events. The bottom three engagement methods identified were program training/activities with staff for peer support and supporting family champions.

Comments: "Incentivize" specialty classes/events to attract family participation such as breastfeeding classes, nutrition education, and family planning targeting specific populations. Further engage with families at town hall-style meetings.

Question 2: How do you collect input or engage families, caregivers and youth?

Findings: The top three mechanisms identified were needs/assets assessments, program activities/service delivery, and development of publications, education/outreach materials. The bottom three mechanisms identified were review/development of program policies and procedures, quality improvement initiatives, and program evaluation and monitoring.

Comments: Responses were based on a loose definition of input which was data collected through BSS and surveys. There is a need to engage more family participation/voices in this area.

Question 3: What are some other methods your program uses to engage families / assure family engagement?

Findings: The top three engagement methods identified were ensure programs reflect diversity of the families being served, support family participation in local, state and national conferences, and use family input when planning, creating and presenting of training materials. The bottom three engagement methods identified were family member as paid program staff, maintain family engagement policy, and designate an AMCHP family delegate for Hawaii.

Comments: Use of the word "ensure" may be overreaching while "strive to reflect" may be more accurate description. Need more family involvement in this area.

Question 4: What assistance do you need that can help increase your family engagement activities?

Findings: The top two needs identified were methods to compensate families/consumers for their time and sharing information/expertise among FHSD programs on how to engage families. The bottom two needs identified were staff training to increase knowledge about family engagement, and assistance finding families/consumers.

Comments: Funding to help support and sustain the Hawaii Parent Leadership Training Institute (PLTI).

Question 5: Please reflect how you feel about this statement: "This survey helped increase my understanding of family engagement opportunities and its importance for program improvement.

Findings: 85% of respondents strongly agree and/or agree, while 15% of respondents neither agree nor disagree and/or disagree.

Comments: These survey questions would be useful in helping programs think about the different avenues that can be used to engage families. Provided ideas on how to better support family engagement (i.e. maintain a family engagement policy).

In summary, family partnership engagement helps to ensure Division programs are effectively addressing the needs of those we serve. As next steps, FHSD reported the findings to staff through a two-page infographics fact sheet and in Spring 2019 fielded a follow-up program survey to develop outreach materials to inform families about partnership opportunities and to identify specific ongoing family engagement support needed across the Title V programs (i.e. number of families needed, types of families, period of time required, and description of activities). The survey results are being analyzed and will be shared with FHSD programs. In addition, a document to share with families is being drafted that can promote family partnership opportunities. FHSD is also exploring ways to procure family incentives and supports for participation in program activities.

FHSD STAFF SURVEY ON FAMILY ENGAGEMENT
June 2018

30 Family Health Services Division (FHSD) programs were invited to participate in a survey on Family Engagement as part of the Title V report to the federal Maternal and Child Health Bureau. 87% (26 surveys completed) of programs responded.

KEY METHODS
"What are some methods you use to engage families?"

FAMILY ENGAGEMENT DEFINITION

The U.S. Maternal and Child Health Bureau defines family/consumer partnership as the "intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course. Family Engagement reflects a belief in the value of family leadership at all levels from an individual, community, and policy level."

COLLECT INPUT
"How do you collect input or engage families, caregivers and youth?"

ASSURE ENGAGEMENT
"What are other methods to assure family engagement?"

Parent Leadership Training Institute (PLTI) Hawaii

FHSD continues to provide technical assistance and financial support to the Parent Leadership Training Institute (PLTI) Hawaii, an evidence-based parent leadership curriculum. Last year, FHSD facilitated the transition of the PLTI lead agency from Parents and Children Together (PACT) to the Hawaii Children's Action Network (HCAN) and also serves on the PLTI advisory board.

PLTI Hawaii Cohort #3 launched in October 2017 with 14 participants. The PLTI curriculum consists of a 20-week training on leadership and civic engagement. All participants are required to plan, implement and evaluate a community project that aims to improve child and family outcomes. A graduation ceremony was held in April 2018 where parents presented their community projects which included the revitalization of a community park/playground, a voter engagement initiative, a family grief and loss program, a youth art program at a transitional shelter, dissemination of aloha bags (sundries, food, resource lists) to the homeless, and a social media safety awareness project.

A small group of dedicated PLTI Hawaii alumni continue to remain active and serve as mentors for future cohorts. The alumni group convenes in-person twice a year as well as communicates via social media. HCAN recently provided opportunities for the alumni to utilize their new skills by participating on agency boards/commissions, and providing testimony on legislative bills. HCAN is working with FHSD to integrate graduates into Title V programs.

To evaluate the effectiveness of PLTI Hawaii, a pre- and post-test are conducted for each cohort and analyzed by a national external evaluator. In June 2017, the first survey of alumni was conducted as part of a longer-term evaluation on the impact of PLTI Hawaii. A second alumni evaluation will be completed in 2018. Next steps for PLTI Hawaii includes the expansion to a rural neighbor island site and securing additional funding. To date, PLTI has been largely funded by a consortium of Title V programs. For more information about PLTI Hawaii visit http://www.hawaii-can.org/plti

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

The primary purpose of State Systems Development Initiative (SSDI) grant is to develop, enhance, and expand state Title V MCH data capacity for its needs assessment and performance measure reporting in the Title V MCH Block Grant program. The key MCH datasets identified in the SSDI grant are used for surveillance, needs assessment, public education and awareness efforts, and evaluation. The table below shows dataset accessibility by Hawaii Title V programs as of FY 2018.

Data Sources	State Has Consistent Annual Access to Data Source	State Has Direct Access to an Electronic Database	State Has Consistent Annual and Direct Electronic Access to Data Source	Describe Periodicity (if available more often than annually; does not need to be direct)	Indicate Lag Length for Most Timely Data Available in Number of Months	Data Source is Linked to Vital Records Birth
1. Vital Records Birth	Yes	No	No		9	
2. Vital Records Death	Yes	No	No		9	Yes
3. Medicaid	No	No	No		-	No
4. WIC	Yes	No	No		6	No
5. Newborn Bloodspot Screening	Yes	Yes	Yes	Quarterly	3	No
6. Newborn Hearing Screening	Yes	Yes	Yes	Quarterly	3	No
7. Hospital Discharge	No	No	No		-	No
8. PRAMS	Yes	Yes	Yes	Annual	24	

Hawaii uses its SSDI funds primarily to support the work of the Hawaii PRAMS program in additional to meeting data requirements for the Title V needs assessment and annual report. SSDI funding is critical to sustain PRAMS operations and staffing. The total annual costs of the Hawaii PRAMS Program (staff salaries, contracted services for data entry/cleaning, printing, postage, etc.) have increased significantly, while the Centers for Disease Control and Prevention (CDC) PRAMS funding has continued to decline. The most recent estimates indicate the current CDC PRAMS grant will cover only 60% of program salary and operations costs. FHSD is exploring ways to reorganize the PRAMS program to utilize the existing grant funds more efficiently including increased use of contracted services.

In 2017, enforcement of a Hawaii Revised Statutes law related to data sharing policies for the Hawaii vital records office severely limited or stopped data sharing from the Hawaii Vital Records office. During the 2018 legislative session, FHSD worked with the Office of Health Status Monitoring to submit a bill to change the law and allow department of health employees access to vital records data. On July 5, 2018, Governor David Ige signed into law Act 135 that adds §338-18.5 to the Hawaii Revised Statutes. Section 338-18.5 is titled “Sharing of vital statistics records with department of health program employees for approved research purposes.” In general, after approval from the Department of Health (DOH) Institutional Review Committee, DOH employees may request and receive individual record level vital statistics data.

The restricted access to vital statistic data also resulted in temporary suspension of Hawaii PRAMS program data

collection which relies on birth records to draw its monthly sample. Based on the change in the law, Hawaii PRAMS data collection resumed in December 2018.

In February 2019, the Institution Research Committee and the Director of Health approved FHSD's ongoing access to birth, death, and fetal death records.

The Healthcare Association of Hawaii (HAH) is the new manager for all hospital data in the state. HAH is the nonprofit trade organization serving Hawaii's hospitals, skilled nursing facilities, assisted living facilities, home care companies, and hospices. The data is managed by a new subsidiary created in 2018, the Laulima Data Alliance. Data is available for purchase. DOH has established a new data governance committee which will include a representative from HAH. This committee will approve and oversee/coordinate all hospital data requests.

All Payers Claim Database (APCD) which would be limited to Medicaid, Medicare, and State Employee Union claims is a joint partnership between DOH, DHS, and the Insurance Commissioner. Is it being managed by DHS through a contract with UH. The data is undergoing quality testing. The Data Analytics Group at DHS will analyze data requests. Several requests for analysis for Department of Health are on the list for analysis. There are no plans to release data directly to researchers at this time.

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

Since 2015, Hawaii switched to a federally-run health exchange, Healthcare.gov, after difficulties sustaining the Hawaii-based exchange. Two insurers offered plans in the Hawaii exchange in 2017: Kaiser Permanente, and Hawaii Medical Service Association (HMSA), the Blue Cross, Blue Shield affiliate. Hawaii's enrollment numbers for private plans offered through the exchange remains relatively small. In 2017, 18,938 people enrolled in private plans through the exchange during open enrollment, which ended January 31st. This was a 30% increase over the previous year, when 14,564 Hawaii residents enrolled. Across all states that use HealthCare.gov, there was an average *decrease* in enrollment for 2017, making Hawaii's enrollment increase significant.

The Title V agency continues to work on advancing the implementation of the Affordable Care Act (ACA) in Hawaii. Most Hawaii Title V programs that provide direct and enabling services encouraged families and individuals served to enroll for health insurance through the federally-run exchange.

The Title V agency's role in ACA is focused on working with stakeholders (including Medicaid) to promote expanded preventive benefits under ACA among consumers and service providers, and assure continued access to care.

The state expanded Medicaid under the ACA. Total net enrollment in Hawaii's Medicaid program grew by more than 53,000 people from the fall of 2013 through March 2017—an 18% increase.

Hawaii's uninsured rate has long been lower than the U.S. average, due to the Hawaii Prepaid Health Care Act. Enacted in 1974, the Act requires employers to provide a group health plan for employees working at least 20 hours a week for at least four straight weeks and earn a minimum of $542/month. The law also mandates a generous set of benefits that must be provided.

Hawaii lawmakers passed Act 111 (2018) to ensure that the following ACA benefits, which may not otherwise be available under the State's Prepaid Health Care Act, remain available under Hawaii law:

- Extending dependent coverage for adult children until the children turn twenty-six years of age;
- Prohibiting health insurance entities from imposing a preexisting condition exclusion; and
- Prohibiting health insurance entities from using an individual's gender to determine premiums or contributions.

Another critical policy passed that will improve Hawaii's healthcare system is Act 55 (2018) which establishes a new Health Analytics Program in the state Medicaid Office and allows the Medicaid program to maintain an All Payers Claims Database (APCD). The APCD is a joint initiative started in 2016 by the DOH, the Office of Enterprise Technology Services, the Department of Human Services, the State Health Planning and Development Agency, the Hawaii Employee-Union Health Benefits Trust Fund, the Department of Commerce and Consumer Affairs Insurance Division, the Department of Budget and Finance, and the University of Hawaii. The database will house information from insurers contracted to provide health benefits financed by the State, primarily health care claims for public employee unions and Medicaid beneficiaries. Act 55 creates the dedicated health analytics capacity needed to analyze the data to improve transparency in the healthcare sector and improve understanding of healthcare costs, quality, population health conditions, and healthcare disparities.

As part of the Department of Human Services (DHS) health transformation efforts Ohana Nui (ON), the state Medicaid program ('QUEST') released a new waiver application/plan for public review and input: the Hawaii Ohana Nui Project Expansion (HOPE) program. The HOPE plan is a five-year initiative to develop and implement a roadmap to achieve the vision of healthy families and healthy communities. To accomplish this overall goal, it was necessary to align government agencies and funding around a common framework: a multigenerational, culturally appropriate approach that invests in children and families over the life-cycle to nurture well-being, and improve individual and population health outcomes. In vison and purpose, the HOPE plan mirrors the DOH strategic plan. The following guiding principles describe the overarching framework that will be used to develop a transformative healthcare system that focuses on healthy families and healthy communities:

- Assuring continued access to health insurance and health care
- Emphasis on whole person and whole family care over their life course
- Address the social determinants of health
- Emphasis on health promotion, prevention and primary care
- Emphasis on investing in system-wide changes

To accomplish the vision and goals, HOPE activities are focused on four strategic areas:

- Invest in primary care, prevention, and health promotion
- Improve outcomes for high-need, high-cost individuals
- Payment reform and alignment
- Support community driven initiatives to improve population health

In addition, HOPE activities are supported by initiatives that enhance three foundational building blocks:

- Health information technology that drives transformation
- Increase workforce capacity and flexibility
- Performance measurement and evaluation

FHSD is aligning Title V goals and objectives with the Medicaid program around this groundbreaking initiative. FHSD will continue to explore opportunities for collaboration and partnerships around the four strategic areas and three foundational building blocks. Examples of current Title V partnerships include:

Current Agreements

- CSHNB/Early Intervention Services (EIS) is working with DHS/Med-QUEST Division (MQD) to amend/update the DHS-DOH MOA related to Medicaid payment for early intervention (EI) services. An amendment to include the provision of EI services via telehealth is under consideration.
- CSHNB/EIS collaborated with DHS/MQD on guidelines and role delineation for collaboration between EIS and QUEST Integration (QI) health plans. A 3/3/17 DHS MQD memo specifies a simple workflow outlining how and when information will be exchanged, and a detailed side by side role delineation of the EIS Care Coordinator and the QI health plan Service Coordinator.
- DHS/MQD clarified in its 5/31/17 memo that EIS may provide Intensive Behavioral Therapy (IBT) services to EI Medicaid children and will transition EI Medicaid children to QI health plans to cover Applied Behavior Analysis (ABA) services for Autism Spectrum Disorder (ASD). An EI Care Coordinator and QI health plan Service Coordinator will collaborate on the transition.

Current Activities

- In 2017, MQD issued two provider memos supporting best practices promoted by the Hawaii Maternal and Infant Health Collaborative (HMIHC) and the DOH Strategic Plan. Memo # QI-1613 supports the One Key Question® (OKQ) screening approach, Long Acting Reversible Contraception (LARC), and expanded access to contraception. Memo QI-1612 supports prenatal Screening, Brief Intervention and Referral to Treatment (SBIRT) pilot project requiring training and reimbursements for participating obstetricians. MQD is now assisting with evaluation of the policies.
- FHSD requests to DHS/MQD for data for Title V annual report/application
- FHSD participates as a member of the EPSDT Advisory Committee.
- Working collaboratively with MQD to process reimbursements for telehealth including the teledentistry pilot.
- With the inclusion of the Project ECHO telehealth program in the HOPE plan, several Medicaid insurance plans have invested funding to sustain and expand the telehealth curriculum offered by the project to rural health providers. In FY 2019 a new training series on pediatric health issues is being developed with this new funding. The project is supported by the FHSD Rural Health office and State Rural Health Association.

Opportunities

- Medicaid is conducting a cost analysis to reinstate adult preventive dental benefits.
- Medicaid payment for specialty formulas and medical foods. WIC is expected to be the payer of last resort for specialty formulas and medical foods. Depending on medical plan and diagnosis, DHS/MQD will pay for entirely tube-fed WIC clients and possibly oral feeding.
- Medicaid payment for childhood lead poisoning prevention activities such as follow-up of elevated blood lead levels. Two states are using Medicaid funding for the state childhood lead funding. http://www.astho.org/Programs/Environmental-Health/Built-and-Synthetic-Environment/Healthy-Communities/State-Stories--Medicaid-Reimbursement-for-Childhood-Lead-Poisoning-Services. Texas has Medicaid reimbursement for childhood blood lead surveillance, data management, case coordination, provider and parent education and environmental lead investigation.
- A new Title V - Title XIX agreement is being developed with our State's Medicaid agency (DHS/MQD). The last agreement was dated 1995. A draft is attached in section IV.

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

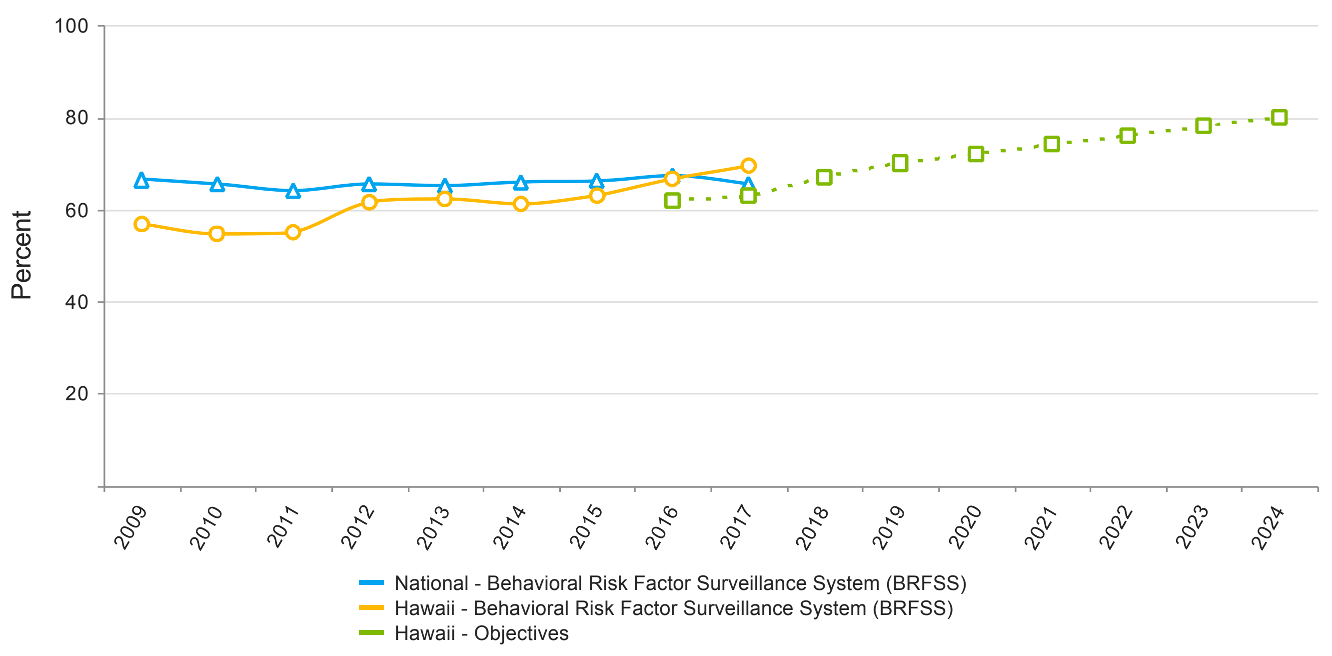
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	126.6	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2017	8.5 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2017	10.4 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2017	28.2 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2016	5.6	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	6.0	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2016	3.8	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	2.3	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2016	216.0	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2015	8.7 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2016	1.1	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	19.1	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2015	9.0 %	NPM 1

National Performance Measures

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



Federally Available Data			
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)			
	2016	**2017**	**2018**
Annual Objective	62	63	67
Annual Indicator	63.0	66.7	69.4
Numerator	152,559	161,334	167,372
Denominator	242,088	241,941	241,254
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	70.0	72.0	74.0	76.0	78.0	80.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of births with less than 18 months spacing between birth and next conception

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		34	31
Annual Indicator	32.7	31.8	31.9
Numerator	3,020	2,851	2,776
Denominator	9,237	8,975	8,698
Data Source	vital statistics	vital statistics	vital statistics
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	31.0	30.0	30.0	30.0	30.0	30.0

State Action Plan Table

State Action Plan Table (Hawaii) - Women/Maternal Health - Entry 1

Priority Need

Promote reproductive life planning

NPM

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

Objectives

By July 2020, increase the percentage of women ages 18 through 44 who had a preventive medical visit in the past year to 72% (Baseline: 2013 Behavioral Risk Factor Surveillance System (BRFSS) data 62.3%)]

Strategies

Promote women's wellness through systems building efforts

Promote pre/inter-conception health care visits

Promote reproductive life planning

ESMs	Status
ESM 1.1 - Percent of births with less than 18 months spacing between birth and next conception	Active

NOMs

- NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations
- NOM 3 - Maternal mortality rate per 100,000 live births
- NOM 4 - Percent of low birth weight deliveries (<2,500 grams)
- NOM 5 - Percent of preterm births (<37 weeks)
- NOM 6 - Percent of early term births (37, 38 weeks)
- NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
- NOM 9.1 - Infant mortality rate per 1,000 live births
- NOM 9.2 - Neonatal mortality rate per 1,000 live births
- NOM 9.3 - Post neonatal mortality rate per 1,000 live births
- NOM 9.4 - Preterm-related mortality rate per 100,000 live births
- NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy
- NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births
- NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
- NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Women/Maternal Health - Annual Report

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

Introduction: Preventive Medical Visit

For the Women/Maternal Health domain, Hawaii continues to focus on improving Well-Women visits by promoting reproductive life planning with plans to include men's health whereby reducing gender inequalities.

Hawaii selected NPM 1 Well-Women visits based on the results of the 5-year needs assessment. By July 2020, the state seeks to increase the number of women who have a preventive medical visit to 72.0% this includes preconception and interconception care. The 2018 indicator reports 69.4% of women in Hawaii received a preventive medical visit, which met the state objective of 67%. The rate was similar to the national estimate of 65.6%. There is no comparable Healthy People 2020 national objective.

This figure has increased from the proportion of women who received preventive medical visits in 2012 (61.6%). Subgroup analysis of the data showed that non-Hispanic White (62.1%) and Hispanic (68.4%) were less likely to have a visit in the past year compared to non-Hispanic Native Hawaiian/other Pacific Islander (72.8%) and non-Hispanic Asian (75.9%) women. Additionally, uninsured women (49.4%) were less likely to have had a visit in the past year compared to those with insurance (70.9%). Women with less than high school education (60.3%) were also less likely have had a visit in the past year compared to the high school graduates (76.2%), those with some college (69.1%) or college graduates (65.0%). There were no differences based on the analysis by age, household income, or marital status.

The leadership for this issue comes from the Title V Women's and Reproductive Health Section. The Section supervisor is partially funded by Title V. The programs in this section also participate in the effort and include the Title X Family Planning program, Perinatal Support Services, and the Adolescent Health program (the coordinator is Title V funded). For the Adolescent Health domain, Hawaii also selected adolescent wellness visits so there is opportunity to partner.

The strategies for this priority reflect the work of the Hawaii's Maternal and Infant Health Collaborative (HMIHC) which has provided leadership for perinatal issues in the state over the last 5 years. Title V has been an integral part of the HMIHC leadership and Steering Committee. Updates for the strategies for this NPM are discussed below.

Strategy 1: Promoting Women's Wellness Visits through Systems Building

Integrating Women's Wellness into State Health Plans and Initiatives

The importance of women's preventive and reproductive health care is reflected in several state health policy/planning documents including:

- The Executive Office of Early Learning Action Strategy plans (specifically the component focused on "Healthy and Welcomed Births"),
- the Hawaii Maternal and Infant Health Collaborative (HMIHC) to improve birth outcomes and reduce infant mortality,
- the state Department of Health Strategic Plan (specifically the component focusing on "Investing in Healthy Babies & Families"), and
- the draft Hawaii Early Childhood State Strategic Plan.

The state plans and collaborative working groups all embrace a life course approach that acknowledges the importance of women's wellness as a foundation for healthier birth outcomes, infants, children and families.

Hawaii Maternal and Infant Health Collaborative (HMIHC)

HMIHC was established as a result of a 2013 National Governors Association Learning Network technical assistance (TA) award to improve Birth Outcomes. The application was submitted by the Title V agency in partnership with the Hawaii March of Dimes. The TA supported a series of planning sessions with a broad group of stakeholders including the Executive Office of Early Learning's (EOEL) Action Strategy Work Group on "Healthy and Welcomed Births."

HMIHC was formed to sustain the plan and implementation activities. HMIHC completed a strategic plan, The First 1,000 Days, aimed at achieving the outcomes of 8% reduction in preterm births and 4% reduction in infant mortality by 2020. To date, over 120 participants across Hawaii have been involved in HMIHC including physicians, clinicians, public health professionals, community service providers, insurance representatives and health care administrators.

Women's preventive health is viewed as a critical factor to reduce infant mortality, improve birth outcomes, and

sustain healthy families. HMIHC has a Pre- and Interconception Work Group focused on promoting optimal health before and between pregnancies in order to increase the number of births in Hawaii that are healthy and welcomed. The Work Group aims to reduce unintended and mistimed pregnancy by increasing clinical, educational and programmatic supports for pregnancy planning across the state.

HMIHC goals for preconception and interconception care are currently:

1. Increase pregnancy intention,
2. increase access to Long Acting Reversible Contraception (LARC), and
3. increase information available on healthy behaviors.

The Title V agency and State Medicaid office are co-convenors for the workgroup that includes the March of Dimes; Hawaii American Congress of Obstetricians and Gynecologists, Hawaii Section (Hawaii ACOG); the University of Hawaii School of Medicine (SOM) Department of Obstetricians, Gynecology, and Women's Health; the Queen's Physicians Network; Healthy Mothers, Healthy Babies; Planned Parenthood; and the Federally Qualified Health Centers. Participation of Medicaid and the FQHCs has been critical to assure services are targeted toward low-income, high-risk women of reproductive age.

The work group meets bi-monthly to share information, network, collaborate on implementation and planning to improve systems building efforts. An annual HMIHC meeting is held to provide updates and secure statewide input from agency/program stakeholders for the year's action plans.

Two evidence based/informed strategies were selected from the federal MCH Bureau Collaborative Improvement and Innovation Network on Infant Mortality (IM CoIIN) targeting women of reproductive age: Long Acting Reversible Contraception (LARC) and the One Key Question® (OKQ) pregnancy intention screening tool. A Hawaii team attended the February 2017 IM CoIIN Learning Session in Houston, Texas, sharing information on partnership building through HMIHC and other state planning efforts targeting women of reproductive age.

Early Childhood Action Strategies

Hawaii's Early Childhood Action Strategy initiative is a research-based, public-private collaborative comprised of over 100 professionals focused on supporting children's health, safety, development and learning. http://hawaiiactionstrategy.org/ Originally, launched under the former Governor's Executive Office on Early Learning the work is divided into 6 cross-disciplinary focus areas:

- Healthy and Welcomed Births
- Safe and Nurturing Families
- On-Track Health and Development
- Equitable Access to Programs and Services
- High-Quality Early Learning Programs
- School Readiness for Successful Transitions

The project coordination is now privately funded. HMIHC leads the Action Strategy's Healthy & Welcomed Births Work Group.

Department of Health Strategic Plan: *Investing in Healthy Babies & Families*

One of the three pillars of the current DOH Strategic Plan is a focus on Investing in Healthy Babies and Families. Women's reproductive health planning and health during pregnancy are an important focus in the plan. Strategies include promotion of the One Key Question® screening tool to decrease unplanned pregnancies and screening pregnant women for substance use to optimize the health of mothers' and assure healthy birth outcomes. The plan is available on the DOH website: https://health.hawaii.gov/opppd/files/2013/04/Hawaii-Department-of-Health-Strategic-Plan-2015-2018-081616.pdf

State Early Childhood Strategic Plan

The State's Executive Office on Early Learning is completing the Early Childhood State Plan 2019-2024, a strategic plan for early childhood to help coordinate and guide all state early childhood efforts. The plan will provide a comprehensive vision that reflects the state's commitment to the children and families of Hawaii with specific measures to monitor and track progress. Key women's health priorities include: promoting preventive screenings for risk factors and assuring access to a medical home.

Strategy 2: Promote pre/interconception health care visits

One Key Question® (OKQ)

Hawaii adopted OKQ as an evidence informed intervention from the federal MCH Bureau IM CoIIN. The OKQ screening protocol encourages providers to routinely ask women about their reproductive health needs to ensure pregnancies are wanted, planned, and healthy by asking "Would you like to become pregnant in the next year?"

Developed by the Oregon Foundation for Reproductive Health (OFRH), OKQ assists women in identifying and clarifying their reproductive desires and goals, with a specific emphasis on promoting highly effective birth control methods for women who do not desire pregnancy. OKQ is also a method to address underlying maternal health conditions and risky health behaviors that may have a detrimental impact on both mother and baby's health before, during, and after pregnancy. This strategy focuses on a women's intent rather than what she plans since the concept of pregnancy planning does not always resonate with all ages, cultures, and backgrounds. OKQ developers advocate for screening in every healthcare encounter to address a woman's changing desires and goals. Regardless of the reason for a women's visit, the use of OKQ provides opportunities for a broad array of service providers to engage women in planning for their reproductive and general health needs.

In January 2016, HMIHC launched the One Key Question® initiative at its annual statewide meeting with keynote speaker Michele Stranger Hunter, Executive Director of the OFRF. Ms. Hunter also conducted OKQ training sessions for providers on implementation of the screening tool into their practices. OKQ was widely accepted at participating health care facilities and service programs forming a group of pilot sites for Hawaii implementation. Three Title V programs integrated OKQ into their service delivery: WIC, family planning, and the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). By September 2018, there were over 199 providers trained and 4,956 individuals reached with OKQ; and, over 150 individuals provided with information on birth spacing via "How long should I wait before getting pregnant again?" brochure (March of Dimes).

Policy. The November 2016 enactment of the state Medicaid Memo No. QI-1613 One Key Question and Contraceptive Coverage https://www.acog.org/-/media/Departments/LARC/HawaiiMedicaidLARCnotice20161110.pdf continues to increase access to contraceptive care by eliminating prior authorization for Medicaid reimbursement and allows health plans to reimburse for dispensing up to 12-months of oral contraceptive supplies. The policy was developed in partnership with the HMIHC.

To increase access to contraception, the 2017 the legislature passed Act 067 which authorizes pharmacists to prescribe and dispense self-administered hormonal contraceptive supplies to patients, regardless of a previous prescription from an authorized prescriber. The law does require pharmacists to refer patients to their primary care provider upon prescribing and dispensing the contraceptive supplies. If the patient does not have a primary care provider, the pharmacist shall advise the patient to consult a licensed physician, advanced practice registered nurse, or other primary care provider of the patient's choice. In 2018, the Oregon State College of Pharmacy, in partnership with the University of Hawaii at Hilo, Daniel K. Inouye College of Pharmacy, offered the Comprehensive Contraceptive Education and Certification for the Hawaii Pharmacist to fulfill the requirements of HRS 461-11.6. As of September 2018, eighteen pharmacists are certified to prescribe and administer FDA approved contraceptives.

Promotion. The 2018 annual HMIHC statewide conference featured updates to implementation of OKQ, increased access to LARC, and review of data collection efforts. Breakout sessions included OKQ. The Pre-Interconception Work Group collected important stakeholder input that was used to update/revise the work plan and training. This included development of a locally-produced OKQ video to promote the initiative and engage more providers. An initial 5,000 OKQ informational brochures were printed by the Title V agency Family Planning program and distributed to providers interested in the initiative. An additional 1,400 were distributed this period.

OKQ Trainings. Based on the rapid success of the OKQ provider trainings and the lessons learned from implementation, the Pre-Interconception Work Group focused on developing local training capacity to sustain (and broaden) the effort. The Work Group identified several Hawaii OKQ trainers that have served as future resources. The Work Group also expanded access to OKQ trainings through use of webinars based on statewide interest.

OKQ trainings were hosted by HMIHC as well as integrated into the annual Home Visiting and Early Childhood Conference. The Healthy Mothers Healthy Babies Coalition of Hawaii, through a March of Dimes Hawaii Chapter grant, completed eight statewide OKQ trainings for ten community health centers and other community partners. OKQ information was also provided through other public health initiatives including provider trainings sponsored by Title V programs: Zika Prevention and Family Planning Care for Non-Pregnant Women and Men of Reproductive Age. By December 2017, a total of 339 providers were trained.
The trainings have evolved based on the experience and feedback from OKQ providers. Additionally, many non-clinical providers requested further training/information on contraceptive options, referral resources, and assistance to address challenging situations including working with adolescents.

The One Key Question® training curriculum was expanded to include an overview of reproductive life planning and contraception, dealing with challenging client scenarios, and community resources. Participants are now given the knowledge required to effectively and sensitively introduce the concept of family planning, birth spacing, and setting

family planning goals, information to dispel common myths about pregnancy and safe sex (a substantial problem among adolescents), and ways to create a client-centered focus that allows for ambivalence, uncertainty, and individualized approaches. An OKQ comprehensive information packet was developed and integrated into OKQ trainings to assist providers. The Title V Family Planning program assisted with packet development, printing and distribution.

Messaging: SafeSex808
Social media has been employed to promote OKQ and help women (teens) to access reliable healthcare information and services. The University of Hawaii School of Medicine Department of Obstetricians, Gynecology, and Women's Health created Safe Sex 808 (https://safesex808.org/ or https://www.instagram.com/safesex808/), a Hawaii based, online resource to find sexual health resources and locate a nearby reproductive health provider. The online resource has been promoted by HMIHC and Title V programs, including the DOH's Adolescent Health program.

Long Acting Reversible Contraception (LARC)
LARC is the most effective form of reversible contraception and has the highest continuation rates among reversible methods. A single visit or encounter is required for placement and continuing use does not require additional medication or regular follow-up. The immediate postpartum period has several potential benefits for implant insertion or IUD placement because many women are motivated to avoid short-interval pregnancy and the physician and women are together, eliminating the need for an additional visit and potential loss of insurance coverage postpartum. Placing LARC in the immediate postpartum period is additionally effective because many women at highest risk of short interpregnancy intervals, may have low postpartum visit follow-up rates.

HMIHC's Pre-Interconception Work Group activities focused on clarifying policies for LARC insurance reimbursement: 1) immediately postpartum prior to hospital discharge, and 2) for outpatient visits for women of reproductive age. In addition, denied claims for LARC insurance reimbursement are reviewed to work out processing issues for various hospital and medical providers. A chart with reimbursement codes for LARC continues and to be distributed by HMIHC and through provider partnerships such as Hawaii ACOG.

LARC Provider Training. The Title V Family Planning program in partnership with the University of Hawaii School of Medicine Department of Obstetricians, Gynecology, and Women's Health conducts regular training for obstetrician–gynecologists and other obstetric care providers on LARC insertion as well as counseling protocols to improve access to LARC for immediate postpartum initiation.

Policy. As a result of the HMIHC partnership, the state Medicaid program provider memorandum supporting OKQ and Contraception Use also clarified Medicaid reimbursement of inpatient LARC, unbundled reimbursement from the global fee for inpatient services, and supported stocking of the contraceptives (particularly LARC devices) in the hospitals listing billing codes for providers. Also, the memo promotes increased access to contraceptive care by eliminating prior authorization for preventive contraceptive procedures, methods or devices in a plan's formulary including reimbursement for dispensing of up to a 12-month supply of oral contraceptives. The memo was sent to all Hawaii Medicaid health plans, hospitals, pharmacies, physicians, physician assistants, midwives, and advanced practice nurses in addition to being posted on the Hawaii ACOG website and distributed through HMIHC. The OKQ and Contraceptives memo mainly focused on using pregnancy intention screening to access contraceptive, inpatient LARC reimbursement for inpatient facilities, and outpatient dispensing of 12-month oral contraceptives (consistent with Act 205 of 2016).

Evaluation. This Medicaid policy impacted Oahu birthing hospitals. Several hospitals are now establishing protocols for stocking LARC in their inpatient pharmacies. HMIHC is working to evaluate its LARC promotion efforts. HMIHC recently received a grant from the National Institute for Reproductive Health to assess whether the 13 birthing hospitals in Hawaii are stocking and receiving reimbursements for LARC inpatient insertion postpartum and to address any barriers. The evaluation to identify administrative barriers to LARC at the state's two largest hospitals is in progress. The grant hopes to identify and partner with provider champions in each hospital to become advocates and early adopters of inpatient insertion of LARC. Lastly, the grant will be used to generate similar LARC policy changes among private health insurers in Hawaii. HMIHC is also in the process of requesting Medicaid billing data for LARC ordering and insertion.

Strategy 3: Promote reproductive life planning

In FY2018, the DOH Title X Family Planning Services program, provided comprehensive statewide family planning services to 16,002 clients in 24,435 visits. Services include client-centered education and counseling, pregnancy testing and counseling, basic infertility services, preconception health, sexually transmitted disease/human

immunodeficiency virus testing, and other related preventive health services including referrals (i.e. blood pressure screening, weight management and domestic violence and intimate partner violence screenings, tobacco cessation, cervical and breast cancer screening). Over 80% of the Hawaii Title X clients leave with their chosen contraceptive method. Of these, 66% leave with a moderately to highly effective method. Family participation in services is encouraged for all clients. All clients are also encouraged to return for their annual exams to ensure continued coordinated compliance with their family planning method and assessment of other health needs. As noted earlier, most of the Family Planning providers integrated One Key Question® (OKQ®) in family planning and primary care services.

In April 2018, the Family Planning program participated in discussions with First Circuit Family Court Judge Bode Uale (Lead for the Juvenile Division), his colleagues, and other juvenile justice stakeholders on the topics of pregnancy prevention, adolescent sexual and reproductive health. The Family Planning program provided resource materials on reproductive health (including OKQ information) which helped to integrate the topic into court-related youth programs that serve teens at high risk for unplanned pregnancy and sexually transmitted infections.

ESM 1.1 - Percent of births with less than 18 months spacing between birth and next conception.
The Evidence Based/Informed Strategy Measure (ESM) selected for women's preventive medical visits is the percent of births with less than 18 months spacing out of total births. The measure is related to one of HIMHC goals for preconception and interconception care (women's preventive health) to improve birth spacing through reproductive life planning education and counseling. The FFY 2018 indicator is 31.9% of births met the recommended birth spacing criteria. The data is provisional. The 2018 objective (31%) was met.

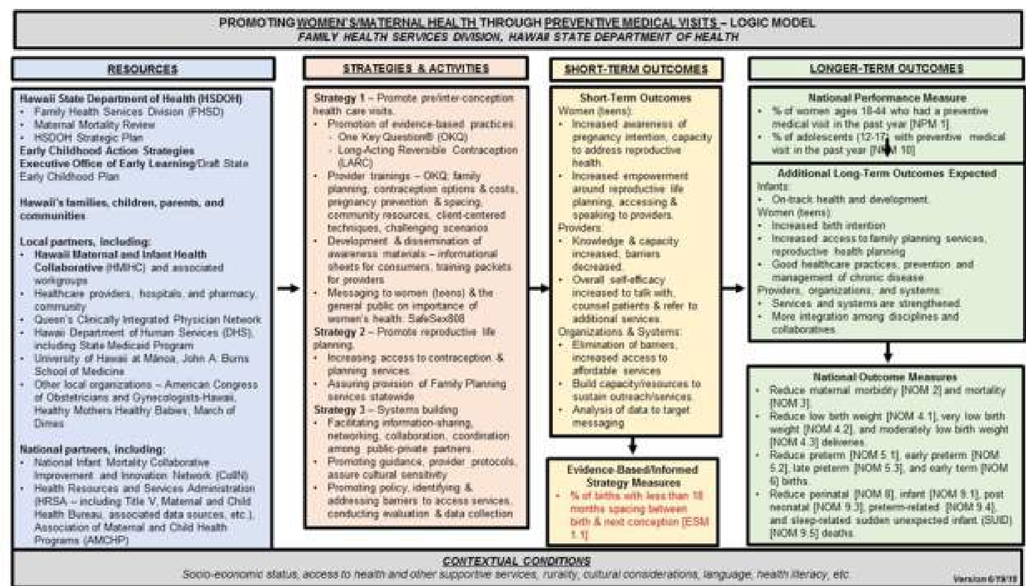
Hawaii recognizes the need to revise the ESM from a population-based health outcome to a process measure to monitor progress on the specific strategies and activities. However, this process was delayed until the hiring of a new Women's Health Section Supervisor. The Supervisor, who co-chair the HMIHC Pre-Interconception Work Group, will revise the ESM in next year's report after consultation with the HMIHC to integrate/align goals, performance and evaluation measures.

Review of the Action Plan

A logic model was developed for NPM 1 to review the alignment between the strategies, activities, measures and desired outcomes. By working on these three strategy areas, Hawaii plans to increase the percentage of women ages 18 through 44 who had a preventive medical visit. The activities for this measure have changed slightly to reflect the program focus of the HMIHC Pre-Interconception Work Group. The Work Group partnership has been critical to the success of engaging a broad array of agencies and community organizations to promote women's reproductive health including preventive health visits. Thus, a systems building strategy was added last year. Sustaining the HMIHC has been challenging and does take dedicated resources/staffing.

The importance of women's wellness visits does not start at age 18 but is an important practice for adolescents particularly females since reproductive health concerns are often more critical for sexually inexperienced and maturing teens. Hawaii's efforts to promote women's wellness visits have coordinated well with efforts to also promote adolescent wellness visits. Thus, NPM 10 is integrated into the logic model.

Hawaii decided to focus on use of the two-evidence based/informed strategies: OKQ and LARC. Health messaging and education efforts for both providers and consumers focus on OKQ, LARC as well as contraceptive options. Short-term outcomes include increased awareness of pregnancy intention, capacity to address reproductive health for women, increased empowerment around reproductive life planning, accessing and speaking to providers. For providers, short term outcomes include: increased knowledge, capacity, and efficacy to counsel clients on reproductive health and refer to community resources. Systems changes include elimination of barriers to services, building of sustainable practices, and collection/analysis of data for evaluation. The ESM on birth spacing, although population based, is expected to show improvements as progress continues.



Longer term outcomes include the Title V NPM to increase preventive medical care and the national outcome measures. Additional long-term outcomes expected include increased birth intention, increased access to family planning services, improved healthcare practices, prevention and chronic disease; which will lead to improve birth outcomes and infant health; and strengthened services and systems, and more integration among disciplines and collaboratives.

Challenges, Barriers

Some of the ongoing challenges to implementing activities include

- Establishing, coordinating and implementing linkages to ensure timely data for monitoring OKQ and LARC benchmarks
- Staffing to oversee activities for the OKQ implementation and related follow-up
- Potential hospital barriers to LARC such as pharmacy stocking of LARC, private insurance coverage of the device, and streamlining administrative processes for reimbursements.

Overall Impact

The Title V agency capitalized on key state and national resources to advance activities to improve women's health that directly impact birth outcomes and reduce infant mortality. These resources include:

- Strong partnerships with the Department of Human Services Medicaid program resulting in policy changes to promote and support evidence-based strategies to promote women's health
- The former Executive Office of Early Learning's Action Strategy Planning process which was supported by the Governor's Office in conjunction with substantial funding commitment from the Hawaii Community Foundation/Omidyar Foundation
- Selection and engagement in the 2013 National Governor's Association (NGA) Learning Network to improve Birth Outcomes
- Participation in the national MCH Bureau Infant Mortality CoIIN
- Willingness of Title V and other programs to integrate OKQ into service delivery for women.

Additionally, Title V used the resources of key partners to provide leadership, staffing and funding to sustain these collaborative efforts over the past five years. These resources are crucial since the MCH Branch recently experienced significant staff turnover, retirements and funding cuts. An example of the collaborative efforts include the funding for the state HMIHC Coordinator through the Preventive Health and Health Services Block Grant (PHHSBG), administered by the DOH Office of Planning, Policy and Program Development. The grant funding is critical to sustaining the momentum and work of the HMIHC including the OKQ and LARC activities as well as workforce training.

Although funding is available, HMIHC is now challenged with seeking a qualified candidate for the Coordinator position charged with supporting the Collaborative work groups and Steering Committee.

The Title V Women's Health Section Supervisor, who also co-chaired the Pre-Interconception Work Group, was vacated in 2018 and was filled recently in the current federal fiscal year by the former PRAMS program coordinator.

Women/Maternal Health - Application Year

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

For the Women/Maternal Health domain, Hawaii selected NPM 1 Well-Women visit based on the results of the 5-year needs assessment. By July 2020, the state seeks to increase the number of women who have a preventive medical visit to 72.0% this includes preconception and interconception care. Plans to address this objective and NPM are discussed below.

The HMIHC Pre-Interconception Work Group plans include some of the following activities:

- Continue work by the University School of Medicine, Ob-Gyn department, to assess and address barriers to implementation of Medicaid policy on LARC at Hawaii's 13 birthing hospitals including stocking of LARC, insertion of LARC inconjunction with delivery, processing of reimbursement, and accessing Medicaid billing data through the National Institute for Reproductive Health grant;
- Continue to assess the need for provider training on changes to LARC coverage and codes, placement and removal of devices, and client counseling to increase provider competency;
- Complete a study of OKQ use at an FQHC serving predominantly Native Hawaiian/Pacific Islanders to assure the OKQ approach does not conflict with multi-cultural views regarding pregnancy planning and spacing;
- Continue to conduct clinical and non-clinical OKQ implementation training targeting primary care providers;
- Continue to develop methods to track, monitor, evaluate OKQ data across programs and agencies;
- Develop a second-high quality, interactive OKQ training video using latest adult learning concepts that captures many of the lessons learned from the first two years of OKQ implementation including working with Hawaii's culturally diverse population;
- Develop general health messaging for reproductive age women, promoting the importance of prevention including medical wellness visits.

Based on the success of trainings, both clinical and non-clinical OKQ provider trainings will continue. The ESM for NPM 1 will be revised based on the activities of the HMIHC Pre-Interconception Work Group.

HMIHC, CoIIN, EOEL Action Strategies efforts will continue. Title V programs will continue to participate to promote women's reproductive health initiatives. Activities include assessing progress to date, identifying opportunities for continued improvement in reducing infant mortality, promoting cross-state collaborations and identifying new approaches, improving use of data, and collecting input from partners and the community to update/revise workplans to promote practice improvement. The HMIHC leadership team and work groups will continue to meet monthly. Discussions will continue to address the priority of preventive medical visits.

Title V Women's Health Programs

Women's Health programs administered by the Hawaii Title V include:

Women Infants and Children (WIC): The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a federally funded program that provides Hawaii residents with nourishing supplemental foods, nutrition education, breastfeeding promotion and health and social service referrals. The participants of WIC 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.

Perinatal Support Services: strives to reduce risk factors that contribute to infant mortality and provides an array of services to address risk factors that lead to poor birth outcomes. Contracts for services that provides services to high-risk pregnant women through pregnancy and six months post-partum.

Family Planning Services: assists individuals in determining the number and spacing of their children and promotes positive birth outcomes and healthy families. Education, counseling and medical services available through federal and state funded clinical programs. The program provides leadership for the implementation of One Key Question® (OKQ) – "would you like to become pregnant in the next year?" OKQ supports reproductive life planning, decreases unplanned pregnancies, and promotes healthy birth outcomes.

Adolescent Health Services: Spans across the physical, mental and social emotional aspects of adolescents and young adults ages 10-24 years of age. Concentration on sexual health, positive youth development and transitioning into adulthood.

Hawaii Home Visiting: provides comprehensive Early Identification (EID) with birthing hospitals, physicians, WIC clinics and Community Health Centers to refer expectant families and families of newborns to home visitation services to improve birth, health and development outcomes and reduce health disparities for high risk families in communities at greatest risk

Pregnancy Risk Assessment Monitoring System (PRAMS): is a population-based surveillance system to identify and monitor maternal experiences, attitudes, and behaviors from preconception, through pregnancy and into the inter-conception period.

Maternal Mortality Review: a multidisciplinary review of maternal deaths intended to prevent future deaths occurring during pregnancy and within one year of giving birth.

Domestic Violence Fatality Review: the purpose of the child, maternal, and domestic violence fatality reviews is to reduce the incidence of preventable deaths in our community. The fatality review process analyzes systems responses by community agencies and other organizations involved.

Child Death Review: a statewide surveillance system for child deaths from ages 0-18 years to reduce preventable deaths to infants, children and youth through multidisciplinary and interagency reviews.

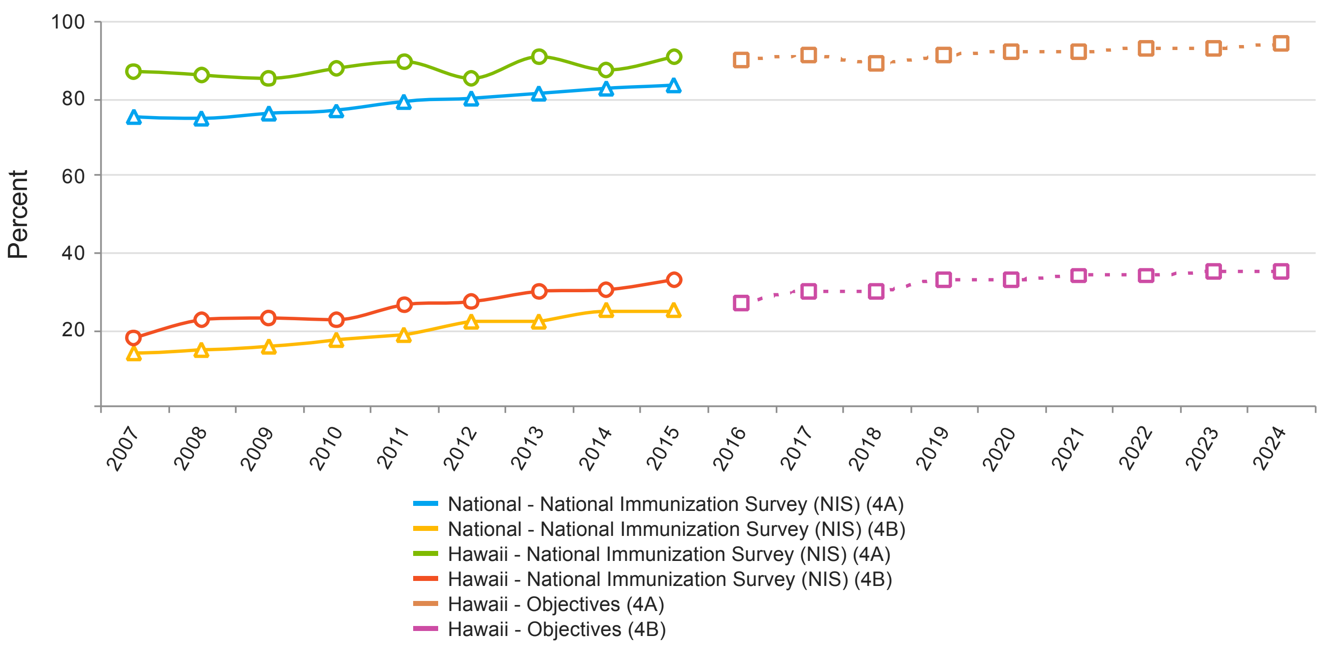
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	6.0	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	2.3	NPM 4 NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2016	94.1	NPM 4 NPM 5

National Performance Measures

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



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	**2017**	**2018**
Annual Objective	90	91	89
Annual Indicator	90.6	87.3	90.6
Numerator	15,214	15,007	15,313
Denominator	16,789	17,199	16,911
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	91.0	92.0	92.0	93.0	93.0	94.0

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

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	**2017**	**2018**
Annual Objective	27	30	30
Annual Indicator	30.1	30.2	32.9
Numerator	4,828	5,029	5,396
Denominator	16,071	16,662	16,415
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	33.0	33.0	34.0	34.0	35.0	35.0

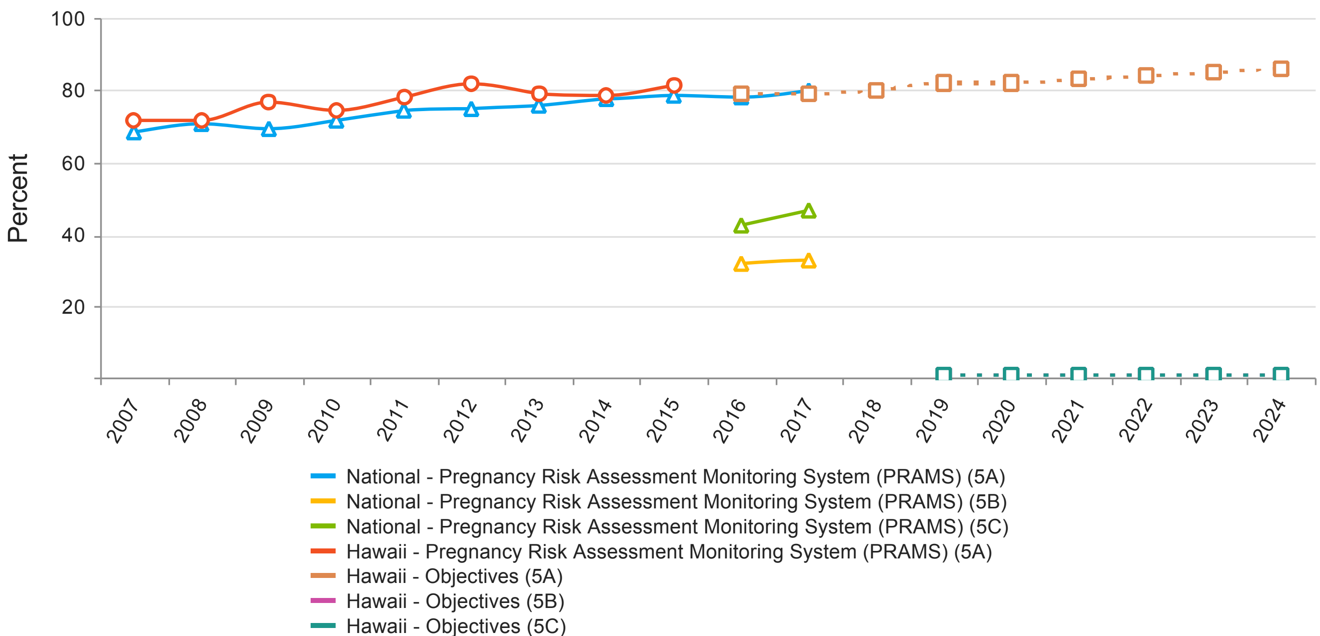
Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percent of Women, Infants, and Children (WIC) infants ever breastfed

Measure Status:	Active		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		81	81
Annual Indicator	80.6	80.6	80.6
Numerator	12,996	12,996	12,996
Denominator	16,132	16,132	16,132
Data Source	HI WIC Services Program	HI WIC Services Program	HI WIC Services Program
Data Source Year	2016	2016	2016
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	82.0	83.0	84.0	85.0	86.0	87.0

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding Indicators and Annual Objectives



National - Pregnancy Risk Assessment Monitoring System (PRAMS) (5A)
National - Pregnancy Risk Assessment Monitoring System (PRAMS) (5B)
National - Pregnancy Risk Assessment Monitoring System (PRAMS) (5C)
Hawaii - Pregnancy Risk Assessment Monitoring System (PRAMS) (5A)
Hawaii - Objectives (5A)
Hawaii - Objectives (5B)
Hawaii - Objectives (5C)

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

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2016	**2017**	**2018**
Annual Objective	79	79	80
Annual Indicator	79.2	81.5	81.5
Numerator	14,243	14,376	14,376
Denominator	17,975	17,634	17,634
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	82.0	82.0	83.0	84.0	85.0	86.0

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

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

State Provided Data		
	2017	2018
Annual Objective		
Annual Indicator	100	100
Numerator	1	1
Denominator	1	1
Data Source	1	1
Data Source Year	1	1
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

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

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

State Provided Data		
	2017	2018
Annual Objective		
Annual Indicator	100	100
Numerator	1	1
Denominator	1	1
Data Source	1	1
Data Source Year	1	1
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Percent of birthing hospitals with current protocols that align with the American Academy of Pediatrics' Recommendations for a Safe Infant Sleeping Environment

Measure Status:	Inactive - Completed		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		60	100
Annual Indicator	66.7	91.7	100
Numerator	8	11	
Denominator	12	12	
Data Source	Safe Sleep Hawaii	Safe Sleep Hawaii	Safe Sleep Hawaii
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

ESM 5.2 - The number of languages in which safe sleep educational materials are available for Hawaii's communities.

Measure Status:	Active				
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	11.0	11.0	11.0	11.0	11.0

State Action Plan Table

State Action Plan Table (Hawaii) - Perinatal/Infant Health - Entry 1

Priority Need

Reduce the rate of infant mortality

NPM

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

Objectives

By July 2020, increase the percent of infants who are ever breastfed to 92% (Baseline: 2011 NIS data 89.5%)

By July 2020, increase the percent of infants breastfed exclusively through 6 months to 33% (Baseline: 2011 NIS data 26.4%)

Strategies

Strengthen programs that provide mother-to-mother support and peer counseling

Partner with community-based organizations to promote and support breastfeeding

Promote collaboration and networking

ESMs	Status
ESM 4.1 - Percent of Women, Infants, and Children (WIC) infants ever breastfed	Active

NOMs

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

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

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

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

Priority Need

Reduce the rate of infant mortality

NPM

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

Objectives

By July 2020, increase the percent of infants placed to sleep on their backs to 82% (Baseline: 2011 PRAMS data 78.1%)

Strategies

Policy Development: Implementation of safe sleep policies at birthing hospitals

Assure competent workforce

Inform, Educate, Empower: Develop appropriate and consistent parental education and general awareness safe sleep messages

ESMs	Status
ESM 5.1 - Percent of birthing hospitals with current protocols that align with the American Academy of Pediatrics' Recommendations for a Safe Infant Sleeping Environment	Inactive
ESM 5.2 - The number of languages in which safe sleep educational materials are available for Hawaii’s communities.	Active

NOMs

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

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

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

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

Introduction: Breastfeeding

Healthy People 2020 establishes breastfeeding initiation, duration, and degree of exclusivity as nationally recognized benchmarks for measuring success. For the Perinatal/Infant Health domain, Hawaii selected NPM 4 (breastfeeding) based on the results of the Title V needs assessment. The first component of the 2020 Title V state objective is to increase the proportion of children who are ever breastfed to 92.0%. The 2018 indicator is from the 2015 National Immunization Survey (latest available data). The estimate for Hawaii (90.6%) failed to meet the annual objective but was higher than the national estimate of 83.2%. The current estimate for Hawaii has not changed significantly since 2009 (84.9%). There were also no significant differences among reported subgroups (birth order, educational attainment, household income, poverty level, marital status, maternal age, and race/ethnicity) based on the 2009-2011 aggregated data provided.

For the second component of the breastfeeding NPM, the 2020 Title V state objective is to increase the proportion of children who are breastfed exclusively through six months to 28.0%. In 2015 (the latest available data), the estimate for Hawaii (32.9%) surpassed the objective, as well as the national estimate of 24.9%. The proportion of Hawaii children breastfed exclusively through six months has increased since 2007 (from 18.0%). Higher risk groups were not assessed due to lack of federally available data.

Breastfeeding was identified as a priority issue for Hawaii during the 2010 and 2015 needs assessments, and continues to be targeted by community stakeholders as an important practice to improve birth outcomes and reduce infant mortality. Hawaii's efforts to improve breastfeeding rates are championed by two important state maternal and child health entities – the Hawaii Maternal and Infant Health Collaborative (HMIHC) and the Early Childhood Action Strategy (previously under the Executive Office on Early Learning) – both of which the Family Health Services Division (FHSD) are key participants.

Within the Title V FHSD, the Women, Infants, and Children (WIC) Services Branch is the lead program for breastfeeding, but works collaboratively with other Title V perinatal/infant health programs and community partners. WIC is the largest public breastfeeding promotion program in the nation, providing mothers with education and support. In addition, WIC trains service providers working with pregnant women and new mothers, and utilizes breastfeeding peer counselors (BFPCs) in select locations.

Hawaii has supportive breastfeeding laws in place. However, the challenge has always been in enforcement and monitoring of such laws and policies. Below are the key breastfeeding laws and legislation in Hawaii:

- Hawaii Rev. Stat. § 367-3 (1999) requires the Hawaii Civil Rights Commission to collect, assemble and publish data concerning instances of discrimination involving breastfeeding or expressing breast milk in the workplace. The law prohibits employers to forbid an employee from expressing breast milk during any meal period or other break period.
- Hawaii Rev. Stat. § 378-2 (2000, Act 227) provides that it is unlawful discriminatory practice for any employer or labor organization to refuse to hire or employ, bar or discharge from employment, withhold pay from, demote or penalize a lactating employee because an employee breastfeeds or expresses milk at the workplace.
- Hawaii Rev. Stat. § 489.21 and § 489-22 provide that it is a discriminatory practice to deny, or attempt to deny, the full and equal enjoyment of the goods, services, facilities, privileges, advantages, and accommodation of a place of public accommodations to a woman because she is breastfeeding a child. The law allows a private cause of action for any person who is injured by a discriminatory practice under this act.
- Hawaii Sess. Laws. (2013, Act 249) requires specified employers to provide reasonable break time for an employee to express milk for a nursing child in a location, other than a bathroom, that is sanitary, shielded from view and free from intrusion. The law also requires employers to post notice of the application of this law in a conspicuous place accessible to employees.
- 2016 Session (Act 46) exempts from jury duty a woman who is breastfeeding or expressing breast milk for a period of two years from the birth of the child.

Although Hawaii's overall breastfeeding rates compare relatively well to national averages, studies show lower rates are associated with low-income households particularly for exclusivity. Therefore, strengthening WIC breastfeeding programs provides a key opportunity to assure a healthy start in life for infants and improved health outcomes for postpartum mothers.

The Hawaii Title V breastfeeding strategies were derived from the *Actions for Communities* section of the 2011

Surgeon General's *Call to Action to Support Breastfeeding* and are generally accepted by Hawaii breastfeeding stakeholders including Breastfeeding Hawaii, the Early Childhood Action Strategy (ECAS) office, the HMIHC, the Perinatal Action Network, Healthy Mothers Healthy Babies, and the March of Dimes.

Strategies to address the objectives and NPMs are discussed below.

Strategy 1: Strengthen programs that provide mother-to-mother support and peer counseling.

One of WIC's core services is to provide breastfeeding education and support to participants. Breastfeeding services include: providing guidance, counseling, and breastfeeding educational materials to families before baby arrives; facilitating access to healthy and varied foods; direct engagement with mothers and families to ensure longer participation in the program; provision of breastfeeding aids such as breast pumps and breast pads; and availability of trained staff in varying roles.

WIC mothers are strongly encouraged to breastfeed their infants unless it is contraindicated for medical reasons. All WIC staff are trained to promote breastfeeding and provide the necessary support new breastfeeding mothers and infants need for success. Federal WIC program regulations require State WIC programs to create policies and procedures to ensure breastfeeding support and assistance is provided throughout the prenatal and postpartum period, particularly when the mother is most likely to need assistance.

WIC provides additional services through a Breastfeeding Peer Counseling (BFPC) Program, which conducts monthly group sessions for pregnant and breastfeeding WIC moms to address breastfeeding concerns and provide one-on-one support to interested WIC moms. Hawaii WIC uses the US Department of Agriculture's (USDA's) *Loving Support©* model, an evidence-based curriculum, to assure the success of the program.

Feedback collected from WIC mothers indicates a high level of satisfaction with the program, particularly the camaraderie shared in the group meetings which is the primary aim of the program (i.e. to provide mothers with a trusted friend who has breastfed). Peer Counselors become part of a mother's "Circle of Care," providing basic breastfeeding information, monthly contacts during the pregnancy and postpartum period, and referrals to designated resources when issues fall beyond their scope of practice. The program is currently located at four WIC offices at community based organizations, as well as three state-run WIC offices. A total of four peer counselors currently service all seven sites. The program is located only on Oahu.

Funding for the BFPC Program comes from USDA and is managed by the WIC Services Branch. Each local office recruits peer counselors and must follow the protocols as outlined in the *Loving Support©* model. Recruitment and retention of peer counselors can be challenging since the positions are part-time and applicants are normally seeking full-time employment.

The strength of the BFPC Program is in the support mothers receive from their peers. In 2018, 12 'baby showers' were completed by BFPCs. The baby showers are meant to allow moms to learn and network with other moms about breastfeeding and other aspects of family life that support breastfeeding duration and exclusivity.

To reinforce breastfeeding promotion (and other important health messages), WIC staff refer clients to the Healthy Mothers Healthy Babies "Text4Baby" service. The service sends enrollees free text messages on prenatal care, baby health, breastfeeding and parenting tips throughout pregnancy and baby's first year of life.

ESM 4.1 is the measure for this strategy: the percent of WIC infants ever breastfed. The numerator is calculated using the number of unduplicated WIC infants who were marked as currently breastfeeding (or if not currently breastfeeding, marked as having previously breastfed). The denominator is the sum of all unduplicated WIC infants.

FY 2018 data continues to be unavailable while WIC transitions to a new method for ad hoc reporting from the management information system. Data will be available for FFY 2017 and 2018 in next year's report. Thus, the FY 2016 ESM indicator of 80.6% is carried forward. The data were collected over the state fiscal year ending June 30, 2016.

Strategy 2: Partner with community-based organizations to promote and support breastfeeding.

WIC partners with community-based organizations to promote and support breastfeeding. Over the past 15 years, WIC has gradually transitioned its service provision from stand-alone state-operated clinics to contracting WIC services with community based organizations like the Federal Qualified Health Centers. These organizations specialize in providing an array of services to low-income and underserved populations, hire staff that often reflect

the diverse cultural groups found in these communities, and have access to language translation resources. Thus, WIC offices located in these organizations may be more effective in reaching WIC clients and providing services, including breastfeeding support.

WIC also works in conjunction with other Title V programs serving high-risk pregnant women by offering breastfeeding education and training to staff, service contractors, and community partners. These programs include the Maternal and Child Health Branch's state-funded Perinatal Support Services program, the Hawaii Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, and the associated MIECHV Hawaii Home Visiting Network.

Strategy 3: Collaboration and networking.

Engaging key partners – Hawaii has an active state breastfeeding coalition, Breastfeeding Hawaii (BH), that works to promote, protect and support breastfeeding through collaboration of community efforts around outreach, legislation, policy enforcement, education, and advocacy. The state WIC breastfeeding coordinator is a board member of BH, and also serves as a liaison to CDC's Division of Nutrition, Physical Activity and Obesity and the United States Breastfeeding Coalition.

As noted earlier, efforts to improve breastfeeding rates are championed by two important state maternal and child health entities: the Hawaii Maternal and Infant Health Collaborative (HMIHC) and the Early Childhood Action Strategy (ECAS). On June 2018, HMIHC and ECAS convened key organizations to revisit the state breastfeeding plan and to identify individuals and/or organizations that could execute new projects or identify existing projects that align with the plan. During the meeting, the identified needs that were found to be of highest importance were:

- guidance regarding insurance reimbursement for lactation support providers who are not primary care providers;
- creation of a toolkit for pediatricians and obstetricians for breastfeeding information; and
- a campaign to communicate a consistent message regarding breastfeeding aimed at the whole family and not just the mother.

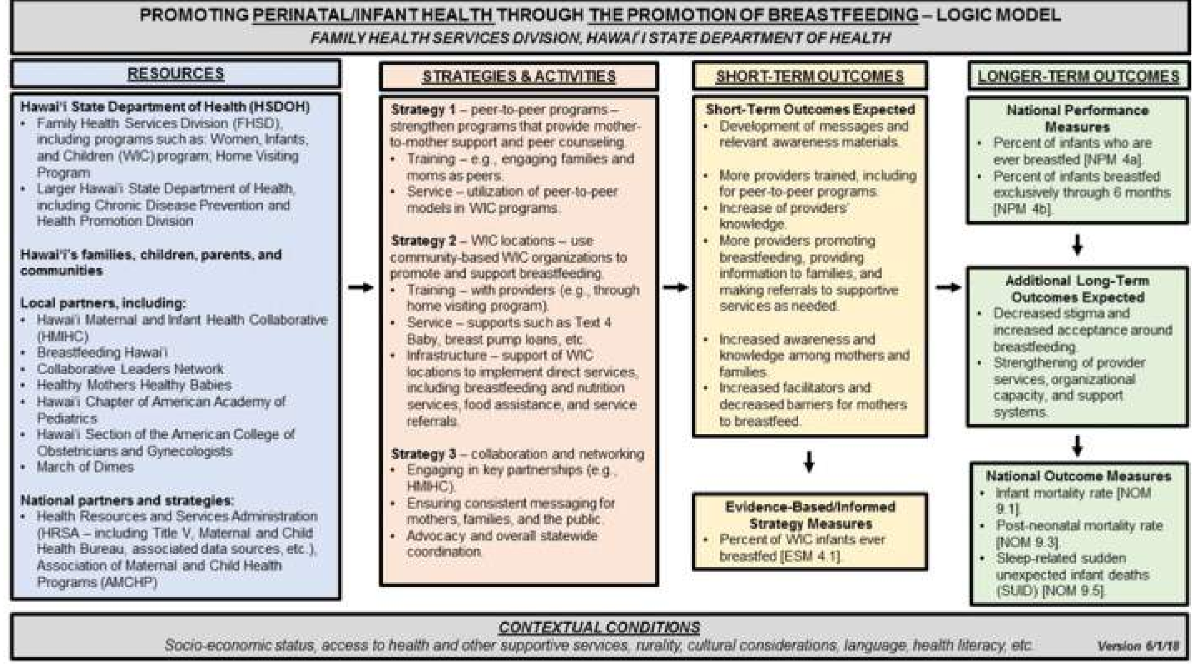
Other participants of the state planning efforts included: Breastfeeding Hawaii, Healthy Mothers Healthy Babies, March of Dimes, University of Hawaii Office of Public Health Studies, University of Hawaii School of Nursing and Dental Hygiene, University of Hawaii John A. Burns School of Medicine, American Academy of Pediatrics – Hawaii Chapter, Kona Community Hospital, Hawaii Public Health Institute, Early Head Start and Head Start, Family Support Hawaii, BAYADA Home Care, La Leche League, Hawaii Mothers Milk, Family Hui Hawaii, several Federally Qualified Health Centers, and Tripler Army Medical Center.

Advocacy/statewide coordination – The Breastfeeding State Plan and its Logic Model focuses on four strategic areas: (1) leadership, (2) messaging & training, (3) laws & policies, and (4) support for families needed at critical junctures during the prenatal/postpartum period. Although there are no funds to implement the Plan, it serves as a guide to align existing breastfeeding efforts conducted by individual organizations and agencies. Without dedicated staffing, it will be challenging to monitor and support plan progress.

Finally, a leadership development training titled *Daring Greatly to Remove Barriers to Breastfeeding* was provided in May 2018 to the same cohort that attended a previous workshop on Secrets of Baby Behavior. This workshop aimed to empower those who were previously trained on how to make realistic and sustainable changes in the hospital. These were sponsored by the DOH Chronic Disease Prevention and Health Promotion Division as part of their ongoing Baby-Friendly Hospital Initiative.

Review of Action Plan

A logic model was developed for NPM 4 to review the alignment between the strategies, activities, measures and desired outcomes. By working on these strategies, the Hawaii Title V program plans to meet the breastfeeding objectives for ESM 4.1 and NPM 4 to increase the percentage of infants breastfed.



The common thread through all three strategies is to increase the points of contact within a mother's circle-of-care. To differentiate between strategies which focus on direct service delivery to mothers and families, versus larger systems development and improvement (i.e., policy, environment), a third strategy was added to the 5-year plan for breastfeeding. Systems work will be critical to assure measured progress for the NPM.

Challenges Encountered

WIC enrollments continue to decrease nationally and in Hawaii. While Hawaii has many dedicated breastfeeding advocates and partners, efforts to develop strategies and sustain their implementation in the community has been difficult due to the lack of a Statewide Breastfeeding Coordinator to serve all families, including those not serviced by WIC.

Recruitment and retention of staff for the BFPC program also continues to be a challenge. Reasons for peer counselors leaving the program have varied, including returning to school, deciding to stay home with new baby, need for higher salary, and moving out-of-state.

Despite Hawaii's excellent breastfeeding initiation rate, the CDC's Maternity Practices in Infant Nutrition and Care report shows that birthing facilities in Hawaii still have opportunities for improvement. The report is based on a survey of hospital practices conducted every two years. Areas for improvement include appropriate use of breastfeeding supplements, inclusion of model breastfeeding policy elements, provision of hospital discharge planning support, and adequate assessment of staff competency. Since the benefits of breastfeeding are dose-related, duration and degree of exclusivity need to be reviewed as well.

Hawaii WIC data show that among mothers who stop breastfeeding in the infant's first year of life, the majority stopped between the first 2-4 weeks after hospital initiation. The primary reason mothers cite is not having enough milk. Additional data collection is needed to determine if moms' responses are due to true milk insufficiency or formula supplementation. Such information would greatly inform the breastfeeding support offered by the BFPC, which could be critical to ensuring mothers' continuation of the practice.

Policies that impact a mother's ability to increase her duration and degree of exclusivity also need to be implemented. Paid family leave is supported by the current state Administration, but legislation has not successfully passed.

Overall Impact

The FHSD WIC Services Branch breastfeeding promotion program can access a large high-risk population of pregnant women and young mothers to help promote and support breastfeeding in Hawaii. The Hawaii WIC program services nearly half the births in the state. Despite loss of staffing, WIC state offices and community contractors continue to promote breastfeeding to clients, as well as provide training/resources to WIC contractors and other

community organizations servicing pregnant women and new mothers.

The Affordable Care Act helped promote breastfeeding by requiring breast pump coverage through medical plans. This can assist mothers with lengthening the duration of exclusive breastmilk feeding, especially as new mothers return to work or school.

Additionally, Title V leveraged resources of key partners to provide leadership, staffing, and funding to sustain community based activities beyond WIC. For example, the coordinator for the Hawaii Maternal Infant Health Collaborative helped to convene breastfeeding stakeholders, coordinate statewide planning, and access national technical assistance resources. The Early Childhood Action Strategy also continues to promote breastfeeding and is participating in the HMIHC Breastfeeding Strategic Planning process. The Strategic Plan will be key in seeking resources for breastfeeding efforts such as reinstituting a State Breastfeeding Coordinator position.

Other Title V programs serving high-risk pregnant women also offer an opportunity to promote breastfeeding through education, workforce training, and support services. Partner programs include the MCH Branch Perinatal Support Services program and the Hawaii Home Visiting Network, supported by the Hawaii Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant. In addition, the Title V Early Childhood Comprehensive Systems (ECCS) coordinator ensures breastfeeding is integrated into state systems planning and services where appropriate. Finally, breastfeeding promotion is included in the Executive Office on Early Learning (EOEL) Early Childhood Strategic plan for the state.

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

Introduction: Safe Sleep

For the Perinatal/Infant Health domain, Hawaii selected NPM 5 based on the results of the Title V needs assessment. The 2020 Title V state objective is to increase the proportion of infants placed to sleep on their backs to 82.0%. Data from 2015 (latest available data) showed that Hawaii nearly met that objective (81.5%) but exceeded the national average of 75.8%. The proportion of infants placed to sleep on their backs has increased significantly since 2007 (from 71.7%). Analysis of Hawaii PRAMS 2012-2015 aggregated data revealed Native Hawaiian mothers were less likely to place their infants on their back (72.9%), compared to Filipino (82.5%), White (86.3%), Chinese (87.6%), and Japanese (89.0%) mothers. Mothers that were under 20 years of age (70.0%) and 20-24 years of age (75.5%) were less likely to place their infants on their back to sleep, compared to mothers that were 25-34 years of age (82.3%) and 35 or more years of age (82.4%). Mothers who were on Medicaid/QUEST during prenatal care were less likely to place their infants on their back to sleep (76.2%), compared to mothers on private or military (82.4%) insurance.

In the latest Title V guidance, two additional safe sleep measures were added to determine whether infants are placed on an approved sleeping surface and placed with soft objects or loose bedding that may endanger infant safety. Data for these two measures are not available at this time for Hawaii.

The Title V needs assessment confirmed the importance of providing safe sleep education and training to parents and childcare providers as a priority issue. The Hawaii Maternal and Infant Health Collaborative (HMIHC) and Early Childhood Action Strategy (ECAS) have identified the promotion of safe sleep practices as an important priority to improve birth outcomes and reduce infant mortality. Specifically, the HMIHC identified two priority strategies to achieve the objective of decreasing infant mortality in the first year of life: 1) Foster safe sleep practices for all who care for infants; and 2) Provide professional development and training opportunities for caregivers of infants.

Although safe sleep is part of the Title V Maternal and Child Health Branch (MCHB) program efforts, implementation of the strategies is a collaboration across the Family Health Services Division (FHSD). MCHB provides general support and leadership through its Parenting Support Programs (PSP), as well as Safe Sleep Hawaii (SSH) which is a statewide partnership that promotes life-saving safe sleep techniques, policies, and education for parents, teachers, health professionals, and other caregivers. The CSHN Branch nurse manager for the Newborn Metabolic Screening program has also integrated safe sleep into the work of the Perinatal Nurse Managers Task Force (PNMTF) which represents all birthing hospitals. There is no dedicated funding source for Safe Sleep staffing or program activities; however, Title V funded staff help to support overall Safe Sleep efforts.

Strategies to address the objectives and NPMs are discussed below.

Strategy 1: Policy Development – Implementation of safe sleep policies at birthing hospitals.

This strategy focuses on identifying, reviewing, and monitoring birthing hospitals' safe sleep policies, protocols, and guidelines. The strategy emerged from Hawaii's participation in the federal MCH Bureau Infant Mortality CoIIN (Collaborative Improvement and Innovation Network) as well as new national AAP Safe Sleep guidelines. The state PNMTF has been critical to implementing this strategy. The CSHN Branch nurse convenes the PNMTF, and membership includes at least one perinatal nurse manager from each of Hawaii's twelve birthing hospitals. Meetings are held quarterly via teleconference; in person annually; and ad-hoc teleconferences as needed. The main focus of the PHNTF is policy development and promotion of the most recent version of the AAP evidence-based recommendations for a Safe Infant Sleeping Environment at birthing hospitals, child care centers, and child care providers. More specifically, the PNMTF works to identify, obtain, review, and monitor birthing hospitals' safe sleep policies, protocols, and guidelines; and, assure compliance with the most recent AAP safe sleep guidelines. Implementation of Safe Sleep policies and practices at all birthing hospitals help assure families are exposed to SS messaging, particularly our high-risk families.

The ESM 5.1 for this strategy is the "Percent of birthing hospitals with current American Academy of Pediatrics safe sleep protocols." The PHMTF collects and reports the data for this measure. The objectives for the ESM were set in partnership with SSH. The FFY 2018 indicator for ESM 5.1 is 100%, meaning all hospitals completed implementation in the FY 2018. This ESM has been fully achieved, and therefore will be inactivated.

Strategy 2: Assure Competent Workforce.

This strategy focuses on identifying safe sleep competency training needs for birthing hospital professionals and meeting those needs with evidence-based/informed information/trainings. The PNMTF continues to focus on assuring a competent workforce and keeping regular staff trained on the most recent safe sleep environment recommendations, and also recognizes the need to provide training opportunities for new nurses. Birthing hospitals do not have safe sleep environment as a workforce competency. However, it is discussed at discharge and included on the discharge check list. However, hospitals utilize various means to promote safe sleep education including creation of safe sleep committees, and promotion of information at staff skills fairs. In addition, a standing agenda topic at some sites' staff meetings is the need for consistent teaching and messaging, and encouraging staff to access the safe sleep trainings for nurses on the National Institute of Child Health and Human Development website. The CSHNB nurse on the PNMTF serves as the hospitals' Safe Sleep subject matter expert and provides technical assistance and training on safe sleep environment policy, protocol development, and guidance on related issues.

Strategy 3: Inform, Educate, Empower. Develop appropriate and consistent parental education and general awareness safe sleep messages.

This strategy focuses on identifying decision-makers, key partners, and resources to develop safe sleep messages for parents and others who care for infants. The Safe Sleep Hawaii Program (SSH) Coordinator of the MCHB is responsible for managing the service contract for the SSH Facilitator, coordinating the efforts relating to safe sleep within MCHB, and acting as "point person" for all safe sleep related inquiries and activities. The facilitator contract is state-funded. Services are contracted with a Registered Nurse Facilitator whose responsibilities include:

- convening SSH quarterly meetings;
- identifying relevant safe sleep materials and opportunities;
- maintaining SSH membership and list serve;
- convening the sub-committee on identifying American Academy of Pediatrics (AAP) approved on-line training courses for caregivers at child care facilities;
- providing ad-hoc safe sleep advice; and
- coordinating a yearly Safe Sleep Summit.

The Nurse Facilitator is also contracted by the DOH Injury Prevention Program (which is not under Title V) to coordinate the State Child ('Keiki') Injury Prevention Coalition (KIPC), thus integrating SS into overall child injury prevention efforts.

SSH focuses on developing appropriate and consistent parental education and general awareness of safe sleep practices in adherence to the most current version of the *AAP Evidence Based Recommendations for a Safe Infant Sleeping Environment at Birthing Hospitals, Child Care Centers, and Child Care Providers.*

A diverse group of representatives make up SSH's membership (see Table 1 below) with representation from government, non-profit, for-profit, and grass-roots organizations and sectors, as well as families who have a commitment to preventing infant mortality through safe sleep practices. In-person SSHC meetings are held quarterly and ad-hoc teleconferences are scheduled as needed.

Table 1: Safe Sleep Hawaii Coalition Membership

ORGANIZATION	COUNTY
Adventist Health Castle	Honolulu
Child and Family Services	Statewide
Department of Health – Maternal Child Health	Statewide
Department of Health – FHSD	Statewide
Department of Health – FHSD – Public Health Nursing	Statewide
Department of Human Services	Statewide
Hawaii AAP	Statewide
Hawaii Primary Care Association	Statewide
Healthy Mothers Healthy Babies	Statewide
Kaiser Permanente	Statewide
Kapiolani Medical Center for Women and Children	Honolulu
Keiki Injury Prevention Coalition	Statewide
March of Dimes	Statewide
Military (Navy)	Statewide
PATCH (People Attentive to Children)	Statewide
Private Citizens	Honolulu
Queens Medical Center	Honolulu
Shriners Hospital for Children	Statewide
Waianae Coast Comprehensive Health Center	Honolulu
Wilcox Medical Center	Kauai

Data to Inform Program Planning/Policy

To encourage the use of data to inform program planning, an Infant Safe Sleep Fact Sheet was developed using data from PRAMS and the Child Death Review (CDR) program. This fact sheet provides general information on Sudden Unexpected Infant Deaths (SUID), SIDs, and data trends, and highlights the importance of creating a safe sleep environment. This fact sheet is accessible via the HI-PRAMS website @ http://health.hawaii.gov/fhsd/home/hawaii-pregnancy-risk-assessment-monitoring-system-prams/. This fact sheet was shared with PRAMS steering committee members, the SSH, the CDR program, and other key stakeholders. Plans are to develop new and update existing fact sheets relating to safe sleep. Proposed topics for further data analysis include examining for correlations between co-sleeping and substance use/abuse.

Safe Sleep Policy for Licensed Child Care Facilities

The Department of Human Services (DHS) Child Care Program is responsible for the licensing of child care facilities statewide and is an important partner to promote safe sleep. The Hawaii Administrative Rules §346-152.7 Safe Sleep Policy and HAR §17-891.1-41 and §17-895-45 Program Requirement was amended in 2017 to require all child care facilities to have a written operational policy regarding safe sleep and ensure all caregivers review those policies and undergo an annual Department of Human Services (DHS) approved training on safe sleep practices. DHS also consulted with the PNMTF and SSH to identify AAP approved on-line training courses to create and enforce safe sleep environment policies. As of September 2018, 78% of the 396 registered and licensed child care facilities have successfully completed the permitting process.

Partnering on Parent/Family Educational Tools

To help with implementation of the safe sleep policy and to support general safe sleep promotion, DHS' Child Care program, the Title V PSP, KIPC, and SSH partnered to develop an educational guide and poster on safe sleep practices for families and providers. This new guide includes:

- AAP recommended guidelines regarding safe sleep environments;
- a letter from a family, "Don't let a preventable infant death happen…,"; and
- a poster that can be displayed in the infant's home, in pediatrician offices, or used as a training tool.

The goal was to provide families with helpful materials that could begin dialogues about safe sleep practices with everyone who cares for their children, whether family or not. The DHS Communication Officer helped oversee the development of the materials.

To ensure the guide was "parent-friendly," families were engaged via survey to provide input for message development and design of the safe sleep materials. Families were also surveyed about their Safe Sleep knowledge. Families from the DHS First-To-Work (FTW) program participated, in addition to families on the state Children's Community Councils. DOH obtained Institutional Review Board approval for the surveys, and conducted an in-service on Safe Sleep for the FTW workers who were administering the survey with families. Most families reported general awareness about safe sleep practices. The information most unfamiliar related to:

- Leaving stuffed animals or toys in the crib;
- Leaving a sleeping baby in a swing;
- Leaving a sleeping baby in a car seat;
- Allowing a baby to sleep on the couch or an air mattress; and
- Allowing smoking in the home.

Families also provided specific feedback on design elements of the poster and guide.

The survey results were incorporated into the Safe Sleep Guide for Parents, as well as a Safe Sleep Guide for Caregivers, both of which were finalized and released in September 2018. The guides have been used by the Child Care program to help with policy implementation. Guides were also distributed by programs such as Women, Infants and Children (WIC), MCH's Child Abuse and Neglect Prevention and Home Visiting Programs, contracted providers at the twelve birthing hospitals throughout the state, and with crib distribution programs sponsored by the Title V MCH Branch.

Promotion of Safe Sleep Environments

The nurse educators who conduct child birth classes at birthing hospitals provide education to parents about safe sleep environments. Two hospitals have used the safe sleep posters in their birthing rooms to stress the importance of providing a safe sleep environment for infants. Nurses have expressed how useful it is to have a poster to refer to when teaching family members about safe sleep.

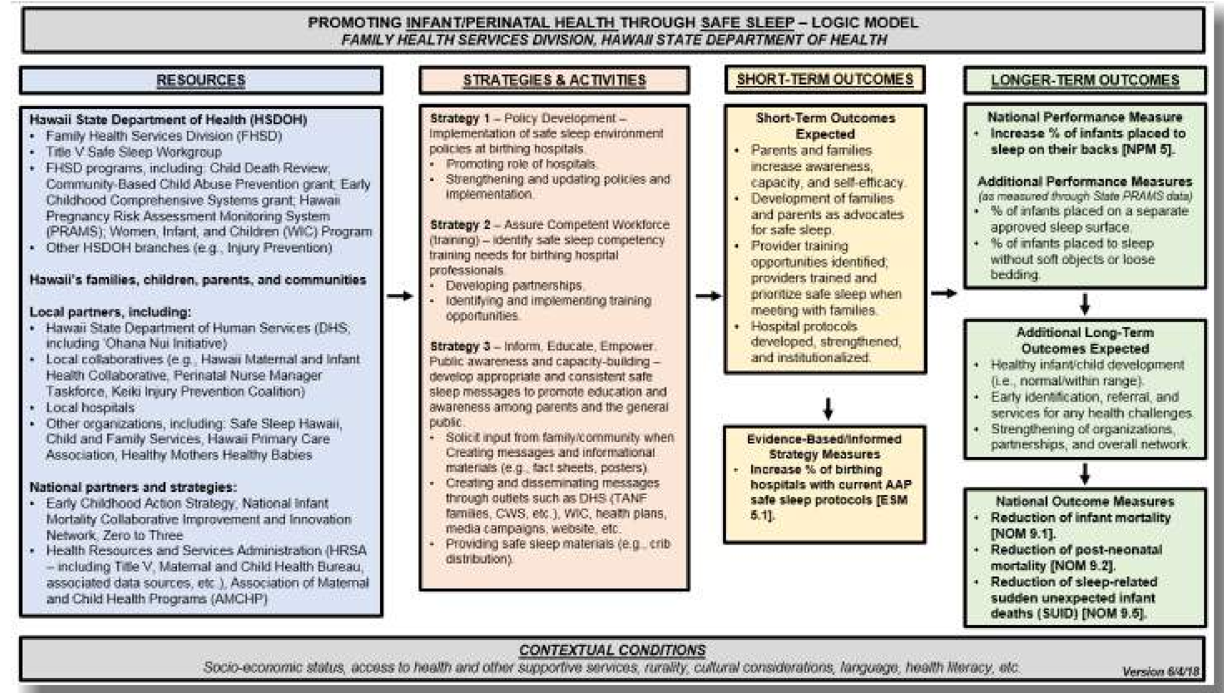
A primary form of messaging provided statewide is the Safe Sleep Hawaii video. The video includes testimony by a family member/advocate, educational information about Safe Sleep practices and environment, and a scenario where parents are communicating with others the need to adhere to Safe Sleep recommendations to ensure the safety of their child. A copy of the Safe Sleep Hawaii video is available for birthing hospitals to play on their internal video site @ http://www.safesleephawaii.org/. The largest maternity hospital in the state requires parents to view the Safe Sleep Hawaii Video prior to discharge.

Pack 'n Play Distribution

Hawaii's Healthy Mothers, Healthy Babies has a "Cribs for Kids®" program targeting low-income families through referrals from various agencies. Parents without a safe sleep environment for their child and are willing to participate in a 1-hour educational session, can receive safe sleep information and a free Pack 'n Play (PNP) portable crib. Some of the birthing hospitals also have their own PNP distribution program for low-income, at-risk families.

Review of the Action Plan

A logic model was developed for NPM 5 to review alignment among the strategies, activities, measures, and desired outcomes. Strategies 1-3 (hospital policy development, assuring a competent workforce (training), and educating families) remain unchanged from previous years. By working on these three strategy areas, Hawaii plans to increase the percentage of infants placed safely to sleep. The activities associated with each of the three strategies directly correlate with short-term outcomes and will impact longer-term outcomes (NPM 5 and NOMs 9.1, 9.2, 9.5). ESM 5.1 was completed in FFY 2018 with all the birthing hospitals becoming compliant with AAP protocols, and therefore will be inactivated. The birthing hospital policy strategy will be replaced with a strategy focusing on outreach to specific high-risk groups, as discussed in the plan narrative.



Challenges Encountered

Challenges continue around messaging and education dissemination.

Messaging

In more than 9 in 10 infant death cases related to safe sleep factors, infants were not sleeping in a crib or bassinet. In addition, nearly 9 in 10 infant death cases related to safe sleep factors involved infants *sleeping with others at the time of death*. In response, initiatives such as 'Pack and Play' distribution and education through the Cribs for Kids Program have proven effective nationally with high risk populations. However, addressing local/cultural beliefs and a general acceptance of co-sleeping has been challenging. The practice may be attributed to the State's ethnic/cultural diversity, as well as economic constraints related to the State's high cost of housing which contributes to the sharing of small dwellings and/or multi-family living arrangements. The data indicate certain ethnic groups, young mothers, and low-income families are particularly at risk. Targeted outreach to diverse cultural populations will be a key strategy in future plans.

Education Dissemination

FHSD will continue to engage with other Title V programs (e.g., WIC and Home Visiting), programs based at birthing hospitals and FQHCs, as well as other "non-traditional" partners such as schools and churches, to expand educational efforts to a broader audience.

Overall Impact

By working together with key stakeholders to address this issue, parents, families, caregivers, and the medical community have increased knowledge and understanding of creating a safe sleep environment for infants. Program activities have successfully addressed safe sleep through a multi-pronged approach consisting of advocacy, policy development, creating a competent workforce, education, supporting safe sleep champions, and grass roots programs/initiatives. These activities, combined with input from parents and families, and the leadership provided by the PNMTF, SSHP, SSHC, and Title V funded staff, have proven successful in mobilizing Safe Sleep efforts. Success of activities may be reflected in the continued increase in proportion of infants placed to sleep on their backs from 2007 (71.7%) to 81.5% in 2015 (PRAMS Data). Hawaii continues to exceed the national estimate of 75.8%.

Title V continues to recognize the importance of feedback provided by families related to message development and

design of safe sleep materials. Families receiving services at the DHS First to Work Program and the Children's Community Councils assisted by completing surveys on safe sleep materials. This input ensured the creation of a family-friendly guide. Proven successful, more work needs to be done to engage family input in the next year's activities. In addition, family engagement has been just one example of the fruitful partnerships with DHS. Not only does this allow the safe sleep program to reach more high-risk populations (e.g., young mothers, those on Medicaid, key ethnic groups), but it also promotes a stronger continuum and system of care for our local families.

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

For the Perinatal/Infant Health domain, Hawaii selected NPM 4 (breastfeeding) based on the results of the Title V needs assessment. The 2020 Title V state objectives are to increase the proportion of children who are ever breastfed to 92.0%, and to increase the proportion of children who are breastfed exclusively through six months to 33.0%.

Work on the three breastfeeding strategies will continue. Some of the major activities include breastfeeding trainings on topics including reimbursements and in, analysis of WIC breastfeeding data to inform program planning, and exploration of ways to expand BFPC to neighbor islands.

The breastfeeding state planning effort led by the HMIHC will continue in FFY 2020. The HMIHC's Infant Health & Safety Team refined its breastfeeding logic model to focus on four strategic areas: (1) leadership, (2) messaging & training, (3) laws & policies, and (4) support for families. Other activities will include:

- Continue breastfeeding trainings for service providers who can assist mothers in overcoming common breastfeeding challenges.
- Referring all pregnant moms served by FHSD programs to the Healthy Mothers Healthy Babies "Text4Baby" service.
- Continue collaborating with the Chronic Disease Prevention and Health Promotion Division on the Baby-Friendly Hospital Initiative.

An update on progress will be provided in next year's Title V report, as well as any needed adjustments to the 5-Year Plan.

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

For the Child Health domain, Hawaii selected NPM 5 Safe Sleep based on the results of the Title V needs assessment. The 2020 Title V state objective is to increase the proportion of infants placed to sleep on their backs to 82.0%. SSH will provide ongoing technical support, and utilize the data and recommendations from child death reviews and the Pregnancy Risk Assessment Monitoring System (PRAMS) to inform safe sleep messages and materials targeting parents and others who care for infants.

The Title V program and Safe Sleep Hawaii (SSH) will continue to focus on activities mentioned in the FY 2018 report, with the exception of ESM 5.1. Since this was completed, the strategy related to policies in birthing hospitals has been inactivated deleted. The remaining Safe Sleep strategies are: 1) assuring a competent workforce; and 2) inform, educate, and empower (parents, families and caregivers). A new strategy has been added: translate educational and general awareness safe sleep messages to languages for non-English speaking populations. The project will be conducted in collaboration with the Department of Human Services (DHS) Child Care Program and the State Office of Language Affairs (OLA).

Workplan highlights for the three strategies are listed below.

Strategy 1: Assure Competent Workforce

- Safe Sleep Hawaii's Annual summit will feature speaker Dr. Rachel Moon who is a leading physician nationally in the field of Safe Sleep practices and behavior change resulting in safe sleep conditions for infants.
- Continue to identify and promote free/sponsored local trainings on safe sleep for professionals.
- Create a list of on-line safe sleep trainings and webinars for professionals.

Strategy 2: Inform, Educate, Empower. Develop appropriate and consistent parental education and general awareness safe sleep messages.

- Develop appropriate and consistent parental education and general awareness safe sleep messages.
- Provide technical assistance on creating safe sleep messages.
- Identify decision-makers, key partners, and resources to develop safe sleep messages for parents and others who care for infants.
- Implement dissemination plan for Safe Sleep Guide for Parents.
- Maintain and update resources on the Safe Sleep Hawaii website @ www.safesleephawaii.org.

- Identify opportunities for messaging that may include social media, radio, and TV.
- Promote the Safe Sleep Hawaii Video.
- In collaboration with existing programs (i.e., Cribs for Kids) identify opportunities and secure funding for additional education and pack n play distribution efforts to meet the continuing need in the community, especially among high risk populations including homeless and new families with minimal access to transportation.
- Engage other programs (i.e., WIC and Home Visiting), programs based at birthing hospitals and FQHCs, and other "non-traditional" partners such as schools and churches, to assist in providing parents and families with information and education on safe sleep environments.
- Evaluate known safe sleep crib distribution and education programs to identify what programs and interventions are effective in addressing at risk populations.
- Look at local and national data and literature relating to safe sleep (e.g., Safe Sleep and Substance Use/Abuse) and disseminate findings to encourage evidence-based program planning, policy development, and decision making.

Strategy 3: Expand outreach to Non-English-speaking families and care givers through translation of educational materials and safe sleep messages.

- Work with the Office of Language Access (OLA) and DHS on the translation of educational materials in most common non-English languages spoken in Hawaii among families accessing DHS services (i.e., Ilocano, Chuukese, Cantonese, Korean, Vietnamese, Samoan, Marshallese, Tagalog, Spanish, Japanese). OLA staff and other community programs were also consulted regarding languages for translation.
- Work with stakeholders and community partners to test and disseminate translated educational materials.
- Work with OLA and DHS to identify/develop opportunities for messaging that will reach the identified communities. Messaging outlets may include, but are not limited to, social media, radio, TV, websites, and printed materials.
- Develop a new ESM 5.2 to measure progress on this new strategy: The number of languages Hawaii safe sleep educational materials are currently available for the community.

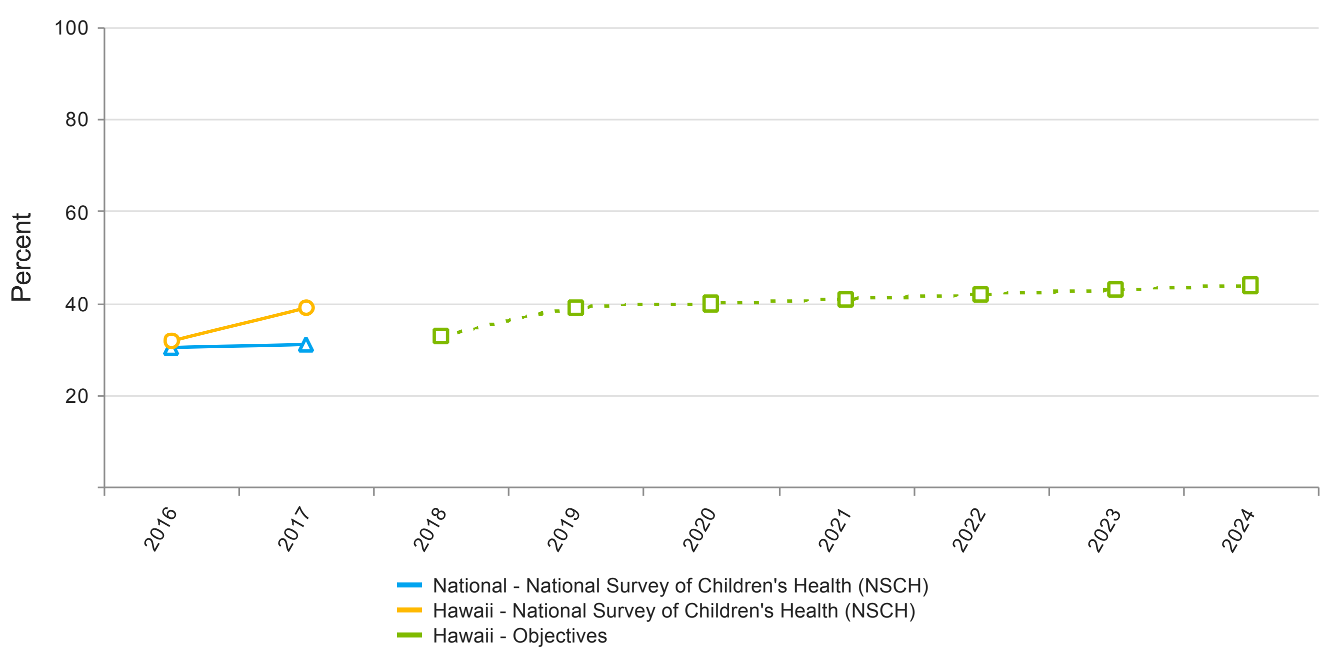
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016_2017	9.5 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	91.3 %	NPM 6 NPM 13.2

National Performance Measures

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



Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			33
Annual Indicator		32.0	39.1
Numerator		12,946	14,121
Denominator		40,486	36,113
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

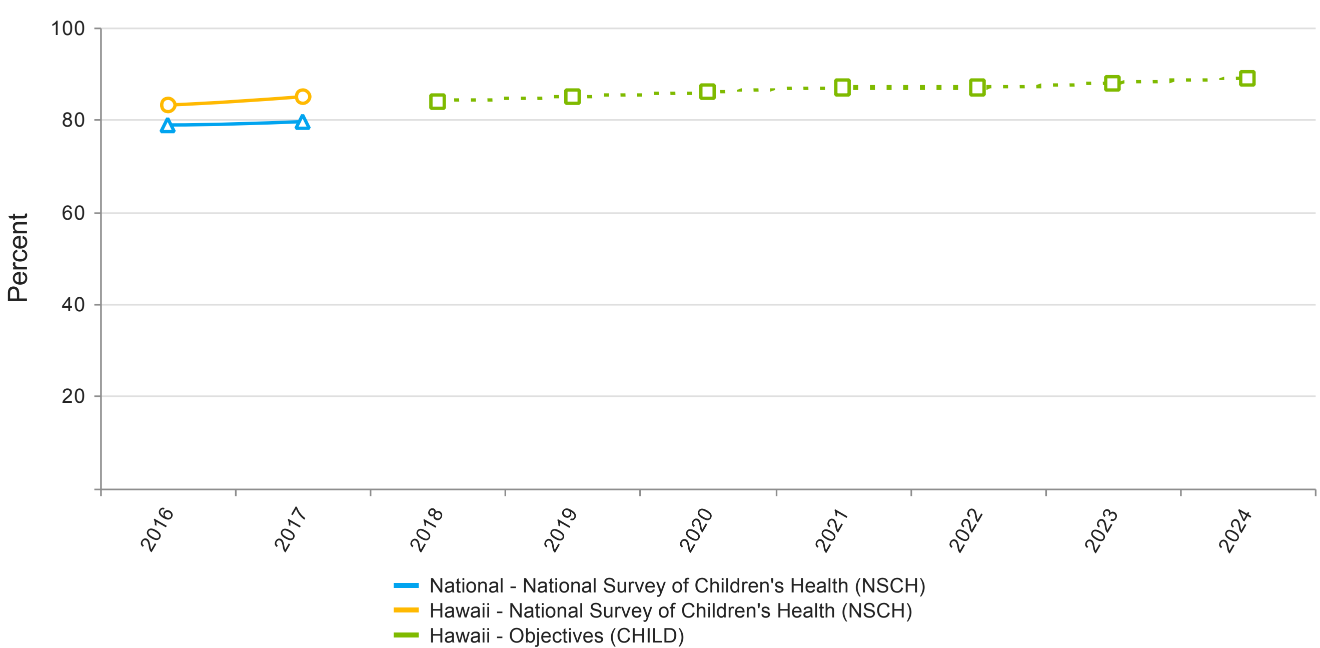
Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	39.0	40.0	41.0	42.0	43.0	44.0

Evidence-Based or –Informed Strategy Measures

ESM 6.2 - Develop and implement Policy and Public Health Coordination rating scale to monitor developmental screening efforts around the areas of systems development, family engagement, data integration, and addressing vulnerable populations

Measure Status:				Active		
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	12.0	18.0	24.0	27.0	30.0	30.0



NPM 13.2 - Child Health

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	2017	2018
Annual Objective			84
Annual Indicator		83.1	84.9
Numerator		243,681	242,790
Denominator		293,312	285,950
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	85.0	86.0	87.0	87.0	88.0	89.0

Evidence-Based or –Informed Strategy Measures

ESM 13.2.2 - Completion of teledentistry pilot project at three early childhood settings to reach underserved children.

Measure Status:	Inactive - Completed		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		Yes	0
Annual Indicator	No	No	Yes
Numerator			
Denominator			
Data Source	Virtual Dental Home Planning Team	Virtual Dental Home Planning Team	Virtual Dental Home Planning Team
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

ESM 13.2.3 - The number of organizations and individuals participating in State Oral Health Coalition meetings and activities

Measure Status:	Active				
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	60.0	65.0	70.0	75.0	80.0

State Performance Measures

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

Measure Status:	Active

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	5.9	5.8	5.8	5.7	5.6	5.6

State Action Plan Table

State Action Plan Table (Hawaii) - Child Health - Entry 1

Priority Need

Improve the percentage of children screened early and continuously age 0-5 years for developmental delay

NPM

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

Objectives

By July 2020, increase the percent of children, ages 9 months through 35 months, who received a developmental screening using a parent-completed screening tool in the past year to 40.0% (Baseline: 2016 NSCH data 32.0%)

Strategies

- Systems Development
- Family Engagement and Public Awareness
- Data Collection and Integration
- Policy and Public Health Coordination
- Social Determinants of Health and Vulnerable Populations

ESMs	Status
ESM 6.1 - Development and implementation of Data sharing system for FHSD programs conducting developmental screening, referrals, and services	Inactive
ESM 6.2 - Develop and implement Policy and Public Health Coordination rating scale to monitor developmental screening efforts around the areas of systems development, family engagement, data integration, and addressing vulnerable populations	Active

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

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

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

Priority Need

Improve the oral health of children

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

By July 2020, increase the percent of children, ages 1 through 17 who had a preventive dental visit in the past year to 86% (Baseline: 2016 NSCH data 83.1%)

Strategies

Develop program leadership and staff capacity

Develop or enhance oral health surveillance.

Assess facilitators/barriers to advancing oral health

Develop and coordinate partnerships with a focus on prevention interventions

Develop plans for state oral health programs and activities

ESMs	Status
ESM 13.2.1 - The establishment of leadership for the State Oral Health Program under the direction of a dental professional and staff with public health skills.	Inactive
ESM 13.2.2 - Completion of teledentistry pilot project at three early childhood settings to reach underserved children.	Inactive
ESM 13.2.3 - The number of organizations and individuals participating in State Oral Health Coalition meetings and activities	Active

NOMs

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

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

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

Priority Need

Reduce the rate of child abuse and neglect with special attention on ages 0-5 years.

SPM

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

Objectives

By July 2020, reduce the rate of confirmed child abuse and neglect cases per 1,000 for children to 5.7 per 1,000 (New objective: baseline 6.1 in 2017)

Strategies

Collaborate on and integrate child wellness and family strengthening activities across programs.

Develop a child abuse and neglect surveillance system.

Raise awareness about the importance of safe and nurturing relationships to prevent child abuse and neglect.

Provide community-based training and technical assistance promoting safe, healthy, and respectful relationships to prevent child abuse and neglect.

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

Introduction: Breastfeeding

Healthy People 2020 establishes breastfeeding initiation, duration, and degree of exclusivity as nationally recognized benchmarks for measuring success. For the Perinatal/Infant Health domain, Hawaii selected NPM 4 (breastfeeding) based on the results of the Title V needs assessment. The first component of the 2020 Title V state objective is to increase the proportion of children who are ever breastfed to 92.0%. The 2018 indicator is from the 2015 National Immunization Survey (latest available data). The estimate for Hawaii (90.6%) failed to meet the annual objective but was higher than the national estimate of 83.2%. The current estimate for Hawaii has not changed significantly since 2009 (84.9%). There were also no significant differences among reported subgroups (birth order, educational attainment, household income, poverty level, marital status, maternal age, and race/ethnicity) based on the 2009-2011 aggregated data provided.

For the second component of the breastfeeding NPM, the 2020 Title V state objective is to increase the proportion of children who are breastfed exclusively through six months to 28.0%. In 2015 (the latest available data), the estimate for Hawaii (32.9%) surpassed the objective, as well as the national estimate of 24.9%. The proportion of Hawaii children breastfed exclusively through six months has increased since 2007 (from 18.0%). Higher risk groups were not assessed due to lack of federally available data.

Breastfeeding was identified as a priority issue for Hawaii during the 2010 and 2015 needs assessments, and continues to be targeted by community stakeholders as an important practice to improve birth outcomes and reduce infant mortality. Hawaii's efforts to improve breastfeeding rates are championed by two important state maternal and child health entities – the Hawaii Maternal and Infant Health Collaborative (HMIHC) and the Early Childhood Action Strategy (previously under the Executive Office on Early Learning) – both of which the Family Health Services Division (FHSD) are key participants.

Within the Title V FHSD, the Women, Infants, and Children (WIC) Services Branch is the lead program for breastfeeding, but works collaboratively with other Title V perinatal/infant health programs and community partners. WIC is the largest public breastfeeding promotion program in the nation, providing mothers with education and support. In addition, WIC trains service providers working with pregnant women and new mothers, and utilizes breastfeeding peer counselors (BFPCs) in select locations.

Hawaii has supportive breastfeeding laws in place. However, the challenge has always been in enforcement and monitoring of such laws and policies. Below are the key breastfeeding laws and legislation in Hawaii:

- Hawaii Rev. Stat. § 367-3 (1999) requires the Hawaii Civil Rights Commission to collect, assemble and publish data concerning instances of discrimination involving breastfeeding or expressing breast milk in the workplace. The law prohibits employers to forbid an employee from expressing breast milk during any meal period or other break period.
- Hawaii Rev. Stat. § 378-2 (2000, Act 227) provides that it is unlawful discriminatory practice for any employer or labor organization to refuse to hire or employ, bar or discharge from employment, withhold pay from, demote or penalize a lactating employee because an employee breastfeeds or expresses milk at the workplace.
- Hawaii Rev. Stat. § 489.21 and § 489-22 provide that it is a discriminatory practice to deny, or attempt to deny, the full and equal enjoyment of the goods, services, facilities, privileges, advantages, and accommodation of a place of public accommodations to a woman because she is breastfeeding a child. The law allows a private cause of action for any person who is injured by a discriminatory practice under this act.
- Hawaii Sess. Laws. (2013, Act 249) requires specified employers to provide reasonable break time for an employee to express milk for a nursing child in a location, other than a bathroom, that is sanitary, shielded from view and free from intrusion. The law also requires employers to post notice of the application of this law in a conspicuous place accessible to employees.
- 2016 Session (Act 46) exempts from jury duty a woman who is breastfeeding or expressing breast milk for a period of two years from the birth of the child.

Although Hawaii's overall breastfeeding rates compare relatively well to national averages, studies show lower rates are associated with low-income households particularly for exclusivity. Therefore, strengthening WIC breastfeeding programs provides a key opportunity to assure a healthy start in life for infants and improved health outcomes for postpartum mothers.

The Hawaii Title V breastfeeding strategies were derived from the *Actions for Communities* section of the 2011

Surgeon General's *Call to Action to Support Breastfeeding* and are generally accepted by Hawaii breastfeeding stakeholders including Breastfeeding Hawaii, the Early Childhood Action Strategy (ECAS) office, the HMIHC, the Perinatal Action Network, Healthy Mothers Healthy Babies, and the March of Dimes.

Strategies to address the objectives and NPMs are discussed below.

Strategy 1: Strengthen programs that provide mother-to-mother support and peer counseling.

One of WIC's core services is to provide breastfeeding education and support to participants. Breastfeeding services include: providing guidance, counseling, and breastfeeding educational materials to families before baby arrives; facilitating access to healthy and varied foods; direct engagement with mothers and families to ensure longer participation in the program; provision of breastfeeding aids such as breast pumps and breast pads; and availability of trained staff in varying roles.

WIC mothers are strongly encouraged to breastfeed their infants unless it is contraindicated for medical reasons. All WIC staff are trained to promote breastfeeding and provide the necessary support new breastfeeding mothers and infants need for success. Federal WIC program regulations require State WIC programs to create policies and procedures to ensure breastfeeding support and assistance is provided throughout the prenatal and postpartum period, particularly when the mother is most likely to need assistance.

WIC provides additional services through a Breastfeeding Peer Counseling (BFPC) Program, which conducts monthly group sessions for pregnant and breastfeeding WIC moms to address breastfeeding concerns and provide one-on-one support to interested WIC moms. Hawaii WIC uses the US Department of Agriculture's (USDA's) *Loving Support©* model, an evidence-based curriculum, to assure the success of the program.

Feedback collected from WIC mothers indicates a high level of satisfaction with the program, particularly the camaraderie shared in the group meetings which is the primary aim of the program (i.e. to provide mothers with a trusted friend who has breastfed). Peer Counselors become part of a mother's "Circle of Care," providing basic breastfeeding information, monthly contacts during the pregnancy and postpartum period, and referrals to designated resources when issues fall beyond their scope of practice. The program is currently located at four WIC offices at community based organizations, as well as three state-run WIC offices. A total of four peer counselors currently service all seven sites. The program is located only on Oahu.

Funding for the BFPC Program comes from USDA and is managed by the WIC Services Branch. Each local office recruits peer counselors and must follow the protocols as outlined in the *Loving Support©* model. Recruitment and retention of peer counselors can be challenging since the positions are part-time and applicants are normally seeking full-time employment.

The strength of the BFPC Program is in the support mothers receive from their peers. In 2018, 12 'baby showers' were completed by BFPCs. The baby showers are meant to allow moms to learn and network with other moms about breastfeeding and other aspects of family life that support breastfeeding duration and exclusivity.

To reinforce breastfeeding promotion (and other important health messages), WIC staff refer clients to the Healthy Mothers Healthy Babies "Text4Baby" service. The service sends enrollees free text messages on prenatal care, baby health, breastfeeding and parenting tips throughout pregnancy and baby's first year of life.

ESM 4.1 is the measure for this strategy: the percent of WIC infants ever breastfed. The numerator is calculated using the number of unduplicated WIC infants who were marked as currently breastfeeding (or if not currently breastfeeding, marked as having previously breastfed). The denominator is the sum of all unduplicated WIC infants.

FY 2018 data continues to be unavailable while WIC transitions to a new method for ad hoc reporting from the management information system. Data will be available for FFY 2017 and 2018 in next year's report. Thus, the FY 2016 ESM indicator of 80.6% is carried forward. The data were collected over the state fiscal year ending June 30, 2016.

Strategy 2: Partner with community-based organizations to promote and support breastfeeding.

WIC partners with community-based organizations to promote and support breastfeeding. Over the past 15 years, WIC has gradually transitioned its service provision from stand-alone state-operated clinics to contracting WIC services with community based organizations like the Federal Qualified Health Centers. These organizations specialize in providing an array of services to low-income and underserved populations, hire staff that often reflect

the diverse cultural groups found in these communities, and have access to language translation resources. Thus, WIC offices located in these organizations may be more effective in reaching WIC clients and providing services, including breastfeeding support.

WIC also works in conjunction with other Title V programs serving high-risk pregnant women by offering breastfeeding education and training to staff, service contractors, and community partners. These programs include the Maternal and Child Health Branch's state-funded Perinatal Support Services program, the Hawaii Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, and the associated MIECHV Hawaii Home Visiting Network.

Strategy 3: Collaboration and networking.

Engaging key partners – Hawaii has an active state breastfeeding coalition, Breastfeeding Hawaii (BH), that works to promote, protect and support breastfeeding through collaboration of community efforts around outreach, legislation, policy enforcement, education, and advocacy. The state WIC breastfeeding coordinator is a board member of BH, and also serves as a liaison to CDC's Division of Nutrition, Physical Activity and Obesity and the United States Breastfeeding Coalition.

As noted earlier, efforts to improve breastfeeding rates are championed by two important state maternal and child health entities: the Hawaii Maternal and Infant Health Collaborative (HMIHC) and the Early Childhood Action Strategy (ECAS). On June 2018, HMIHC and ECAS convened key organizations to revisit the state breastfeeding plan and to identify individuals and/or organizations that could execute new projects or identify existing projects that align with the plan. During the meeting, the identified needs that were found to be of highest importance were:

- guidance regarding insurance reimbursement for lactation support providers who are not primary care providers;
- creation of a toolkit for pediatricians and obstetricians for breastfeeding information; and
- a campaign to communicate a consistent message regarding breastfeeding aimed at the whole family and not just the mother.

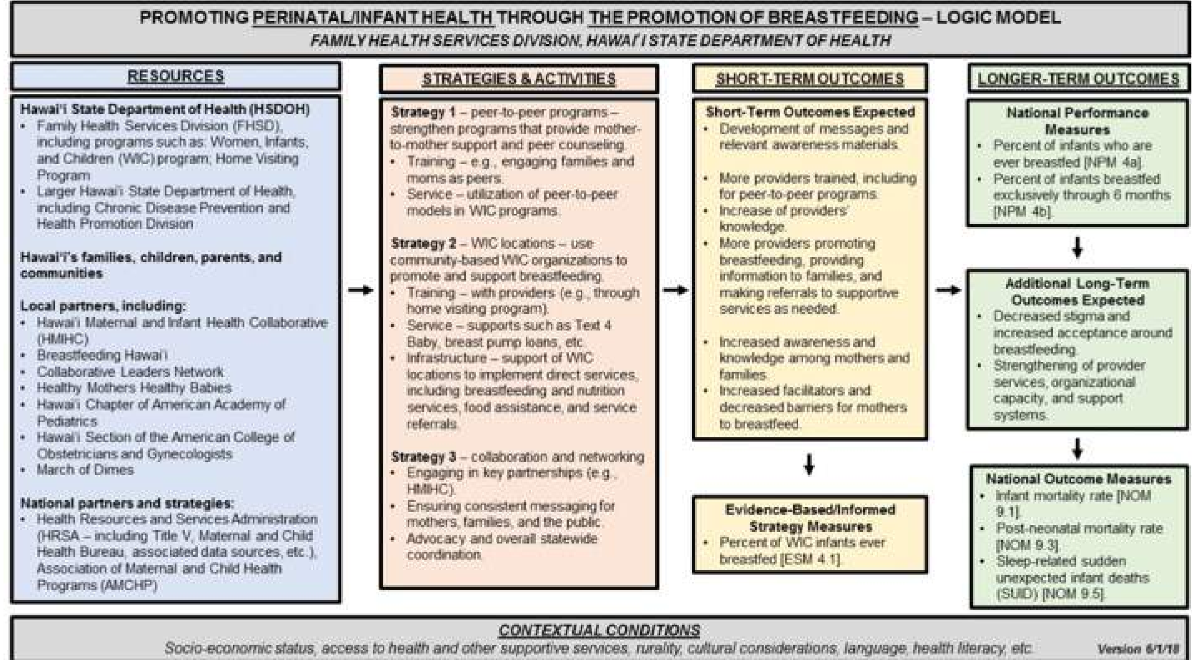
Other participants of the state planning efforts included: Breastfeeding Hawaii, Healthy Mothers Healthy Babies, March of Dimes, University of Hawaii Office of Public Health Studies, University of Hawaii School of Nursing and Dental Hygiene, University of Hawaii John A. Burns School of Medicine, American Academy of Pediatrics – Hawaii Chapter, Kona Community Hospital, Hawaii Public Health Institute, Early Head Start and Head Start, Family Support Hawaii, BAYADA Home Care, La Leche League, Hawaii Mothers Milk, Family Hui Hawaii, several Federally Qualified Health Centers, and Tripler Army Medical Center.

Advocacy/statewide coordination – The Breastfeeding State Plan and its Logic Model focuses on four strategic areas: (1) leadership, (2) messaging & training, (3) laws & policies, and (4) support for families needed at critical junctures during the prenatal/postpartum period. Although there are no funds to implement the Plan, it serves as a guide to align existing breastfeeding efforts conducted by individual organizations and agencies. Without dedicated staffing, it will be challenging to monitor and support plan progress.

Finally, a leadership development training titled *Daring Greatly to Remove Barriers to Breastfeeding* was provided in May 2018 to the same cohort that attended a previous workshop on Secrets of Baby Behavior. This workshop aimed to empower those who were previously trained on how to make realistic and sustainable changes in the hospital. These were sponsored by the DOH Chronic Disease Prevention and Health Promotion Division as part of their ongoing Baby-Friendly Hospital Initiative.

Review of Action Plan

A logic model was developed for NPM 4 to review the alignment between the strategies, activities, measures and desired outcomes. By working on these strategies, the Hawaii Title V program plans to meet the breastfeeding objectives for ESM 4.1 and NPM 4 to increase the percentage of infants breastfed.



The common thread through all three strategies is to increase the points of contact within a mother's circle-of-care. To differentiate between strategies which focus on direct service delivery to mothers and families, versus larger systems development and improvement (i.e., policy, environment), a third strategy was added to the 5-year plan for breastfeeding. Systems work will be critical to assure measured progress for the NPM.

Challenges Encountered

WIC enrollments continue to decrease nationally and in Hawaii. While Hawaii has many dedicated breastfeeding advocates and partners, efforts to develop strategies and sustain their implementation in the community has been difficult due to the lack of a Statewide Breastfeeding Coordinator to serve all families, including those not serviced by WIC.

Recruitment and retention of staff for the BFPC program also continues to be a challenge. Reasons for peer counselors leaving the program have varied, including returning to school, deciding to stay home with new baby, need for higher salary, and moving out-of-state.

Despite Hawaii's excellent breastfeeding initiation rate, the CDC's Maternity Practices in Infant Nutrition and Care report shows that birthing facilities in Hawaii still have opportunities for improvement. The report is based on a survey of hospital practices conducted every two years. Areas for improvement include appropriate use of breastfeeding supplements, inclusion of model breastfeeding policy elements, provision of hospital discharge planning support, and adequate assessment of staff competency. Since the benefits of breastfeeding are dose-related, duration and degree of exclusivity need to be reviewed as well.

Hawaii WIC data show that among mothers who stop breastfeeding in the infant's first year of life, the majority stopped between the first 2-4 weeks after hospital initiation. The primary reason mothers cite is not having enough milk. Additional data collection is needed to determine if moms' responses are due to true milk insufficiency or formula supplementation. Such information would greatly inform the breastfeeding support offered by the BFPC, which could be critical to ensuring mothers' continuation of the practice.

Policies that impact a mother's ability to increase her duration and degree of exclusivity also need to be implemented. Paid family leave is supported by the current state Administration, but legislation has not successfully passed.

Overall Impact

The FHSD WIC Services Branch breastfeeding promotion program can access a large high-risk population of pregnant women and young mothers to help promote and support breastfeeding in Hawaii. The Hawaii WIC program services nearly half the births in the state. Despite loss of staffing, WIC state offices and community contractors continue to promote breastfeeding to clients, as well as provide training/resources to WIC contractors and other

community organizations servicing pregnant women and new mothers.

The Affordable Care Act helped promote breastfeeding by requiring breast pump coverage through medical plans. This can assist mothers with lengthening the duration of exclusive breastmilk feeding, especially as new mothers return to work or school.

Additionally, Title V leveraged resources of key partners to provide leadership, staffing, and funding to sustain community based activities beyond WIC. For example, the coordinator for the Hawaii Maternal Infant Health Collaborative helped to convene breastfeeding stakeholders, coordinate statewide planning, and access national technical assistance resources. The Early Childhood Action Strategy also continues to promote breastfeeding and is participating in the HMIHC Breastfeeding Strategic Planning process. The Strategic Plan will be key in seeking resources for breastfeeding efforts such as reinstituting a State Breastfeeding Coordinator position.

Other Title V programs serving high-risk pregnant women also offer an opportunity to promote breastfeeding through education, workforce training, and support services. Partner programs include the MCH Branch Perinatal Support Services program and the Hawaii Home Visiting Network, supported by the Hawaii Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant. In addition, the Title V Early Childhood Comprehensive Systems (ECCS) coordinator ensures breastfeeding is integrated into state systems planning and services where appropriate. Finally, breastfeeding promotion is included in the Executive Office on Early Learning (EOEL) Early Childhood Strategic plan for the state.

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

Introduction: Safe Sleep

For the Perinatal/Infant Health domain, Hawaii selected NPM 5 based on the results of the Title V needs assessment. The 2020 Title V state objective is to increase the proportion of infants placed to sleep on their backs to 82.0%. Data from 2015 (latest available data) showed that Hawaii nearly met that objective (81.5%) but exceeded the national average of 75.8%. The proportion of infants placed to sleep on their backs has increased significantly since 2007 (from 71.7%). Analysis of Hawaii PRAMS 2012-2015 aggregated data revealed Native Hawaiian mothers were less likely to place their infants on their back (72.9%), compared to Filipino (82.5%), White (86.3%), Chinese (87.6%), and Japanese (89.0%) mothers. Mothers that were under 20 years of age (70.0%) and 20-24 years of age (75.5%) were less likely to place their infants on their back to sleep, compared to mothers that were 25-34 years of age (82.3%) and 35 or more years of age (82.4%). Mothers who were on Medicaid/QUEST during prenatal care were less likely to place their infants on their back to sleep (76.2%), compared to mothers on private or military (82.4%) insurance.

In the latest Title V guidance, two additional safe sleep measures were added to determine whether infants are placed on an approved sleeping surface and placed with soft objects or loose bedding that may endanger infant safety. Data for these two measures are not available at this time for Hawaii.

The Title V needs assessment confirmed the importance of providing safe sleep education and training to parents and childcare providers as a priority issue. The Hawaii Maternal and Infant Health Collaborative (HMIHC) and Early Childhood Action Strategy (ECAS) have identified the promotion of safe sleep practices as an important priority to improve birth outcomes and reduce infant mortality. Specifically, the HMIHC identified two priority strategies to achieve the objective of decreasing infant mortality in the first year of life: 1) Foster safe sleep practices for all who care for infants; and 2) Provide professional development and training opportunities for caregivers of infants.

Although safe sleep is part of the Title V Maternal and Child Health Branch (MCHB) program efforts, implementation of the strategies is a collaboration across the Family Health Services Division (FHSD). MCHB provides general support and leadership through its Parenting Support Programs (PSP), as well as Safe Sleep Hawaii (SSH) which is a statewide partnership that promotes life-saving safe sleep techniques, policies, and education for parents, teachers, health professionals, and other caregivers. The CSHN Branch nurse manager for the Newborn Metabolic Screening program has also integrated safe sleep into the work of the Perinatal Nurse Managers Task Force (PNMTF) which represents all birthing hospitals. There is no dedicated funding source for Safe Sleep staffing or program activities; however, Title V funded staff help to support overall Safe Sleep efforts.

Strategies to address the objectives and NPMs are discussed below.

Strategy 1: Policy Development – Implementation of safe sleep policies at birthing hospitals.

This strategy focuses on identifying, reviewing, and monitoring birthing hospitals' safe sleep policies, protocols, and guidelines. The strategy emerged from Hawaii's participation in the federal MCH Bureau Infant Mortality CoIIN (Collaborative Improvement and Innovation Network) as well as new national AAP Safe Sleep guidelines. The state PNMTF has been critical to implementing this strategy. The CSHN Branch nurse convenes the PNMTF, and membership includes at least one perinatal nurse manager from each of Hawaii's twelve birthing hospitals. Meetings are held quarterly via teleconference; in person annually; and ad-hoc teleconferences as needed. The main focus of the PHNTF is policy development and promotion of the most recent version of the AAP evidence-based recommendations for a Safe Infant Sleeping Environment at birthing hospitals, child care centers, and child care providers. More specifically, the PNMTF works to identify, obtain, review, and monitor birthing hospitals' safe sleep policies, protocols, and guidelines; and, assure compliance with the most recent AAP safe sleep guidelines. Implementation of Safe Sleep policies and practices at all birthing hospitals help assure families are exposed to SS messaging, particularly our high-risk families.

The ESM 5.1 for this strategy is the "Percent of birthing hospitals with current American Academy of Pediatrics safe sleep protocols." The PHMTF collects and reports the data for this measure. The objectives for the ESM were set in partnership with SSH. The FFY 2018 indicator for ESM 5.1 is 100%, meaning all hospitals completed implementation in the FY 2018. This ESM has been fully achieved, and therefore will be inactivated.

Strategy 2: Assure Competent Workforce.

This strategy focuses on identifying safe sleep competency training needs for birthing hospital professionals and meeting those needs with evidence-based/informed information/trainings. The PNMTF continues to focus on assuring a competent workforce and keeping regular staff trained on the most recent safe sleep environment recommendations, and also recognizes the need to provide training opportunities for new nurses. Birthing hospitals do not have safe sleep environment as a workforce competency. However, it is discussed at discharge and included on the discharge check list. However, hospitals utilize various means to promote safe sleep education including creation of safe sleep committees, and promotion of information at staff skills fairs. In addition, a standing agenda topic at some sites' staff meetings is the need for consistent teaching and messaging, and encouraging staff to access the safe sleep trainings for nurses on the National Institute of Child Health and Human Development website. The CSHNB nurse on the PNMTF serves as the hospitals' Safe Sleep subject matter expert and provides technical assistance and training on safe sleep environment policy, protocol development, and guidance on related issues.

Strategy 3: Inform, Educate, Empower. Develop appropriate and consistent parental education and general awareness safe sleep messages.

This strategy focuses on identifying decision-makers, key partners, and resources to develop safe sleep messages for parents and others who care for infants. The Safe Sleep Hawaii Program (SSH) Coordinator of the MCHB is responsible for managing the service contract for the SSH Facilitator, coordinating the efforts relating to safe sleep within MCHB, and acting as "point person" for all safe sleep related inquiries and activities. The facilitator contract is state-funded. Services are contracted with a Registered Nurse Facilitator whose responsibilities include:

- convening SSH quarterly meetings;
- identifying relevant safe sleep materials and opportunities;
- maintaining SSH membership and list serve;
- convening the sub-committee on identifying American Academy of Pediatrics (AAP) approved on-line training courses for caregivers at child care facilities;
- providing ad-hoc safe sleep advice; and
- coordinating a yearly Safe Sleep Summit.

The Nurse Facilitator is also contracted by the DOH Injury Prevention Program (which is not under Title V) to coordinate the State Child ('Keiki') Injury Prevention Coalition (KIPC), thus integrating SS into overall child injury prevention efforts.

SSH focuses on developing appropriate and consistent parental education and general awareness of safe sleep practices in adherence to the most current version of the *AAP Evidence Based Recommendations for a Safe Infant Sleeping Environment at Birthing Hospitals, Child Care Centers, and Child Care Providers.*

A diverse group of representatives make up SSH's membership (see Table 1 below) with representation from government, non-profit, for-profit, and grass-roots organizations and sectors, as well as families who have a commitment to preventing infant mortality through safe sleep practices. In-person SSHC meetings are held quarterly and ad-hoc teleconferences are scheduled as needed.

Table 1: Safe Sleep Hawaii Coalition Membership

ORGANIZATION	COUNTY
Adventist Health Castle	Honolulu
Child and Family Services	Statewide
Department of Health – Maternal Child Health	Statewide
Department of Health – FHSD	Statewide
Department of Health – FHSD – Public Health Nursing	Statewide
Department of Human Services	Statewide
Hawaii AAP	Statewide
Hawaii Primary Care Association	Statewide
Healthy Mothers Healthy Babies	Statewide
Kaiser Permanente	Statewide
Kapiolani Medical Center for Women and Children	Honolulu
Keiki Injury Prevention Coalition	Statewide
March of Dimes	Statewide
Military (Navy)	Statewide
PATCH (People Attentive to Children)	Statewide
Private Citizens	Honolulu
Queens Medical Center	Honolulu
Shriners Hospital for Children	Statewide
Waianae Coast Comprehensive Health Center	Honolulu
Wilcox Medical Center	Kauai

Data to Inform Program Planning/Policy

To encourage the use of data to inform program planning, an Infant Safe Sleep Fact Sheet was developed using data from PRAMS and the Child Death Review (CDR) program. This fact sheet provides general information on Sudden Unexpected Infant Deaths (SUID), SIDs, and data trends, and highlights the importance of creating a safe sleep environment. This fact sheet is accessible via the HI-PRAMS website @ http://health.hawaii.gov/fhsd/home/hawaii-pregnancy-risk-assessment-monitoring-system-prams/. This fact sheet was shared with PRAMS steering committee members, the SSH, the CDR program, and other key stakeholders. Plans are to develop new and update existing fact sheets relating to safe sleep. Proposed topics for further data analysis include examining for correlations between co-sleeping and substance use/abuse.

Safe Sleep Policy for Licensed Child Care Facilities

The Department of Human Services (DHS) Child Care Program is responsible for the licensing of child care facilities statewide and is an important partner to promote safe sleep. The Hawaii Administrative Rules §346-152.7 Safe Sleep Policy and HAR §17-891.1-41 and §17-895-45 Program Requirement was amended in 2017 to require all child care facilities to have a written operational policy regarding safe sleep and ensure all caregivers review those policies and undergo an annual Department of Human Services (DHS) approved training on safe sleep practices. DHS also consulted with the PNMTF and SSH to identify AAP approved on-line training courses to create and enforce safe sleep environment policies. As of September 2018, 78% of the 396 registered and licensed child care facilities have successfully completed the permitting process.

Partnering on Parent/Family Educational Tools

To help with implementation of the safe sleep policy and to support general safe sleep promotion, DHS' Child Care program, the Title V PSP, KIPC, and SSH partnered to develop an educational guide and poster on safe sleep practices for families and providers. This new guide includes:

- AAP recommended guidelines regarding safe sleep environments;
- a letter from a family, "Don't let a preventable infant death happen…,"; and
- a poster that can be displayed in the infant's home, in pediatrician offices, or used as a training tool.

The goal was to provide families with helpful materials that could begin dialogues about safe sleep practices with everyone who cares for their children, whether family or not. The DHS Communication Officer helped oversee the development of the materials.

To ensure the guide was “parent-friendly,” families were engaged via survey to provide input for message development and design of the safe sleep materials. Families were also surveyed about their Safe Sleep knowledge. Families from the DHS First-To-Work (FTW) program participated, in addition to families on the state Children’s Community Councils. DOH obtained Institutional Review Board approval for the surveys, and conducted an in-service on Safe Sleep for the FTW workers who were administering the survey with families. Most families reported general awareness about safe sleep practices. The information most unfamiliar related to:

- Leaving stuffed animals or toys in the crib;
- Leaving a sleeping baby in a swing;
- Leaving a sleeping baby in a car seat;
- Allowing a baby to sleep on the couch or an air mattress; and
- Allowing smoking in the home.

Families also provided specific feedback on design elements of the poster and guide.

The survey results were incorporated into the Safe Sleep Guide for Parents, as well as a Safe Sleep Guide for Caregivers, both of which were finalized and released in September 2018. The guides have been used by the Child Care program to help with policy implementation. Guides were also distributed by programs such as Women, Infants and Children (WIC), MCH’s Child Abuse and Neglect Prevention and Home Visiting Programs, contracted providers at the twelve birthing hospitals throughout the state, and with crib distribution programs sponsored by the Title V MCH Branch.

Promotion of Safe Sleep Environments

The nurse educators who conduct child birth classes at birthing hospitals provide education to parents about safe sleep environments. Two hospitals have used the safe sleep posters in their birthing rooms to stress the importance of providing a safe sleep environment for infants. Nurses have expressed how useful it is to have a poster to refer to when teaching family members about safe sleep.

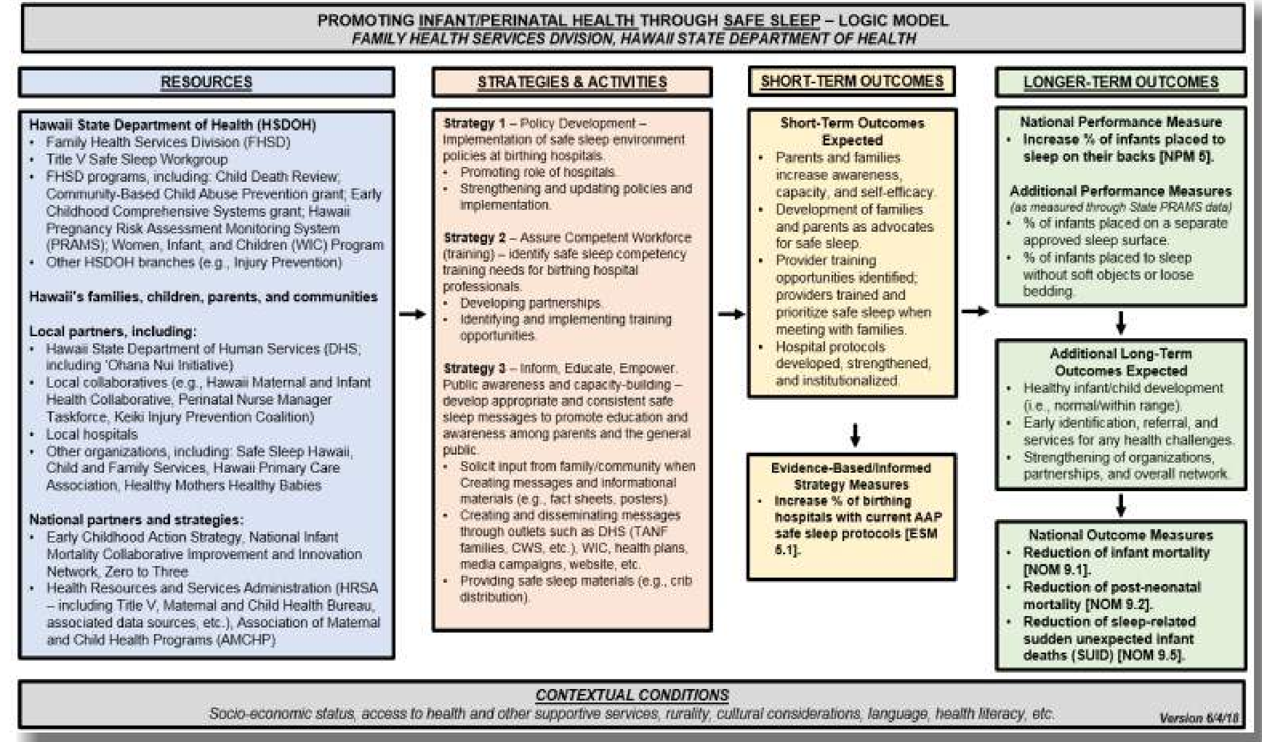
A primary form of messaging provided statewide is the Safe Sleep Hawaii video. The video includes testimony by a family member/advocate, educational information about Safe Sleep practices and environment, and a scenario where parents are communicating with others the need to adhere to Safe Sleep recommendations to ensure the safety of their child. A copy of the Safe Sleep Hawaii video is available for birthing hospitals to play on their internal video site @ http://www.safesleephawaii.org/. The largest maternity hospital in the state requires parents to view the Safe Sleep Hawaii Video prior to discharge.

Pack ‘n Play Distribution

Hawaii’s Healthy Mothers, Healthy Babies has a “Cribs for Kids®” program targeting low-income families through referrals from various agencies. Parents without a safe sleep environment for their child and are willing to participate in a 1-hour educational session, can receive safe sleep information and a free Pack ‘n Play (PNP) portable crib. Some of the birthing hospitals also have their own PNP distribution program for low-income, at-risk families.

Review of the Action Plan

A logic model was developed for NPM 5 to review alignment among the strategies, activities, measures, and desired outcomes. Strategies 1-3 (hospital policy development, assuring a competent workforce (training), and educating families) remain unchanged from previous years. By working on these three strategy areas, Hawaii plans to increase the percentage of infants placed safely to sleep. The activities associated with each of the three strategies directly correlate with short-term outcomes and will impact longer-term outcomes (NPM 5 and NOMs 9.1, 9.2, 9.5). ESM 5.1 was completed in FFY 2018 with all the birthing hospitals becoming compliant with AAP protocols, and therefore will be inactivated. The birthing hospital policy strategy will be replaced with a strategy focusing on outreach to specific high-risk groups, as discussed in the plan narrative.



Challenges Encountered

Challenges continue around messaging and education dissemination.

Messaging

In more than 9 in 10 infant death cases related to safe sleep factors, infants were not sleeping in a crib or bassinet. In addition, nearly 9 in 10 infant death cases related to safe sleep factors involved infants *sleeping with others at the time of death*. In response, initiatives such as 'Pack and Play' distribution and education through the Cribs for Kids Program have proven effective nationally with high risk populations. However, addressing local/cultural beliefs and a general acceptance of co-sleeping has been challenging. The practice may be attributed to the State's ethnic/cultural diversity, as well as economic constraints related to the State's high cost of housing which contributes to the sharing of small dwellings and/or multi-family living arrangements. The data indicate certain ethnic groups, young mothers, and low-income families are particularly at risk. Targeted outreach to diverse cultural populations will be a key strategy in future plans.

Education Dissemination

FHSD will continue to engage with other Title V programs (e.g., WIC and Home Visiting), programs based at birthing hospitals and FQHCs, as well as other "non-traditional" partners such as schools and churches, to expand educational efforts to a broader audience.

Overall Impact

By working together with key stakeholders to address this issue, parents, families, caregivers, and the medical community have increased knowledge and understanding of creating a safe sleep environment for infants. Program activities have successfully addressed safe sleep through a multi-pronged approach consisting of advocacy, policy development, creating a competent workforce, education, supporting safe sleep champions, and grass roots programs/initiatives. These activities, combined with input from parents and families, and the leadership provided by the PNMTF, SSHP, SSHC, and Title V funded staff, have proven successful in mobilizing Safe Sleep efforts. Success of activities may be reflected in the continued increase in proportion of infants placed to sleep on their backs from 2007 (71.7%) to 81.5% in 2015 (PRAMS Data). Hawaii continues to exceed the national estimate of 75.8%.

Title V continues to recognize the importance of feedback provided by families related to message development and design of safe sleep materials. Families receiving services at the DHS First to Work Program and the Children's Community Councils assisted by completing surveys on safe sleep materials. This input ensured the creation of a family-friendly guide. Proven successful, more work needs to be done to engage family input in the next year's activities. In addition, family engagement has been just one example of the fruitful partnerships with DHS. Not only does this allow the safe sleep program to reach more high-risk populations (e.g., young mothers, those on Medicaid, key ethnic groups), but it also promotes a stronger continuum and system of care for our local families.

Child Health - Application Year

NPM-6: Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed screening tool

For the Child Health domain, Hawaii selected NPM-6 Developmental Screening based on the 5-year needs assessment. By July 2022 the state seeks to increase the number of children ages 9 through 35 months, receiving a developmental screening to 40.0%. Plans to address this objective and NPM are discussed below.

Work on the developmental screening 5-year strategies will continue. Hawaii is working with the MCH Evidence Center who provided an ESM Review & Resources for Hawaii's 2017 Report. Based on the review, Hawaii will focus its efforts for FY 2020 on systems development and family engagement. The Hawaii strategies were revised to reflect the adoption of the new ESM 6.2 which utilizes the Policy & Public Health Coordination scale to monitor and track Hawaii's progress on NPM 6. Hawaii will continue technical assistance discussions with the Evidence Center to refine the NPM 6 ESM.

Hawaii will to continue work with partners to implement the statewide system for developmental screening, referral, and services. These efforts will likely be included in a strategic plan for the federal Preschool Development Grant Birth through Five (PDG B-5). Hawaii will work with early childhood partners to develop a strategic plan around developmental screening and address the areas of system development, family engagement and public awareness, and data integration. Hawaii will consider the social determinants of health to assure service accessibility to vulnerable populations. Community level initiatives and input will be used to refine statewide policies, procedures and guidelines.

Hawaii will continue to work at the community level through the federal Health Resources Services Administration (HRSA) Early Childhood Comprehensive Systems Impact (ECCS Impact) Grant. The ECCS Impact grant is focused on Maui County and increasing the number of three-year old children who receive a developmental screen with referral to services and supports if needed. A Coordinator for the grant is now located on Maui who helps to oversee the activities and trainings. The Coordinator convenes a local Maui implementation team, the County of Maui Multi-agency Impact Team (CoMMIT) for Keiki (Keiki means child in the Hawaiian language), which meets bi-monthly to address problems with screenings and referrals.

Hawaii will continue to implement the Public Health and Policy Rating Scale to track Title V-led activities around developmental screenings. It is envisioned that by working in all five areas, a better system of developmental screening will emerge, and more children and families will be supported. The FY 2020 objective is set for 26.

NPM-13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

For the Child Health domain, Hawaii selected NPM-13.2 (children's oral health) based on the five-year needs assessment. By July 2020 the state seeks to increase the percent of children, ages 1 through 17, who had a preventive dental visit in the past year to 86.0%.

While community resources and capacity were bolstered as a result of the CDC Oral Health grant, FHSD continues to explore options for internally rebuilding the State Oral Health Program (SOHP). Therefore, with the ending of the grant, the Title V strategies have been revised substantially to focus on maintaining minimum core functions including surveillance and ongoing coalition-building and planning efforts. The revised strategies are:

- Program Development – Explore & pursue options to staff State Oral Health Program;
- Surveillance – Maintain oral health surveillance activities;
- Partnership-/Coalition-Building – Support ongoing partnerships and coalition-building activities; and
- Planning – Support ongoing planning efforts, with a focus on prevention.

A new ESM has been created tor FY 2020 that focuses on sustaining the state coalition work. ESM 13.2.3 is the number of organizations and individuals participating in State Oral Health Coalition meetings and activities. Coalition-building efforts will continue with DentaQuest Foundation grant funding awarded to the Hawaii Public Health Institute (HPHI). HPHI has been able to hire a dental consultant with public health experience to support ongoing work including policy development and non-profit incorporation of the coalition.

DOH continues to collect oral health data through surveillance surveys including PRAMS, YRBS, and BRFSS. Partnering with the DOH Planning Office, FHSD is continuing to analyze state hospital and emergency department data for oral health-related utilization and has begun discussions to establish an oral health report card on the DOH data warehouse website, Hawaii Health Matters (http://www.hawaiihealthmatters.org/). The Title V Office of Primary Care and Rural Health will continue to monitor workforce shortages including dental services and establishment of federal designations for health professional shortage areas.

Title V will continue to contract with sixteen community-based health service programs (including the Federally Qualified Health Centers) to provide primary care services for the uninsured and under-insured, including dental treatment services. In FY 2020, FHSD has agreed to expand the procedures reimbursed including use of silver diamine fluoride application.

Since the pilot teledentistry program has proven to be sustainable, the WHCHC FQHC, the original pilot site provider, is now in discussions with the Department of Education to expand the program to public elementary schools in their service area. However, several major policy barriers will need to be addressed before the program may begin.

The initial VDH teledentistry pilot has generated substantial interest and requests for expansion of the project across the neighbor islands. DOH, in partnership with the UOP Dental Program, secured funding for a second teledentistry pilot project on the island of Maui working with the Native Hawaiian Health Center. In addition to serving young children, a senior assisted living facility has been included in response to requests by the community. The project also includes an oral health professional educational component in collaboration with the Maui Community College Dental Hygiene School.

SPM-4: Rate of confirmed child abuse and neglect cases per 1,000 children ages 0 to 5 years.

Strategy 1: Collaborate on and integrate child wellness and family strengthening activities across programs.

Collaboration among the state child service systems will continue through efforts such as the Early Childhood Action Strategy (ECAS), the Hawaii Children's Trust Fund (HCTF), the Maui Hoʻoikaika Partnership, the Hawaii Children's Action Network (HCAN), and the Hawaii Children's Bureau State Team. Internal collaboration among Title V and allied DOH programs will also continue.

The CANP program established a new collaboration with the Hawaii State Public Library System, in conjunction with the *Every Child Learning To Read* Program, to promote early literacy. Reading to a child is a simple and easy way for a parent/caregiver to create and maintain a nurturing bond. The CANP program is also sponsoring Family Fun Days on all the islands to encourage family engagement at public libraries. These activities are designed to nurture parent-child relationships, promote healthy child development, and improve parenting skills. All events will continue through FY 2020 and are conducted in collaboration with the CAN coalitions and others working on child maltreatment.

The CANP program is partnering with the Hawaii Public Housing Authority (HPHA) and their Resident Advisory Boards to help promote family violence prevention among this at-risk population. HPHA receives federal public housing (Section 8) funding to develop affordable rental and supportive housing for low income residents. The Community Café approach will be used to create partnerships/engagement between families and their community resources, including schools, faith-based institutions, businesses, family support centers, early childhood programs, health organizations, CAN coalitions, and child care services.

Strategy 2: Develop a Child Abuse and Neglect (CAN) surveillance system.

State health departments are well-positioned to advance and provide leadership for child maltreatment prevention efforts, particularly in the areas of assessment and surveillance of public health problems. Currently, Hawaii has no statewide child maltreatment surveillance system. While multiple sectors are collecting data, there is no common way that data are defined, collected, analyzed, used, and shared. Thus, the CANP is working on development of a CAN surveillance plan. The goal is to apply a systems approach to support data collection and sharing.

Preliminary work on the surveillance plan was done during the MCH Workforce Development Center Skills Building Institute Workshop. The participating Team helped to identify some initial steps and data elements for the development of the surveillance system. Subsequently, the CANP was able to contract with University of Hawaii public health faculty to assist with the project. Activities currently underway, that will continue into FY 2020, include:

- Inventorying of existing secondary data sources relevant to CAN prevalence and risk/protective factors (including ACEs);
- Analysis, synthesis, and dissemination of the data;
- Design of a mapping presentation; and
- Development of tools for subsequent primary data collection.

At present, secondary data sources that will be examined include: Hawaii Department of Human Services, Hawaii hospital emergency departments, military, National Child Health Study, U.S. Census social and economic indicators, the Pregnancy Risk Assessment Monitoring System, the Behavioral Risk Factor Surveillance Survey, and the Youth Risk Behavior Survey. For each data source there will be a description of the data indicators pertinent to CAN rates and risk/protective factors, the collection methodology, geographic granularity (e.g., island, county, zip code, census tract), and demographic variables (e.g., race/ethnicity, age, gender, etc.). A second phase, slated to start in FY 2020, will include collection and analysis of qualitative data relevant to CAN prevention.

Once data collection is completed, factsheets will be designed and developed addressing child abuse and neglect prevention, intimate partner violence prevention, sexual violence prevention, ACEs, and resilience. The fact sheets will combine data from the various sources, as well as provide information about programs, services, and resources. Where possible, the analysis will include mapping of high-risk indicators by island and/or county.

It is anticipated the data and factsheets will be disseminated largely through a virtual "dashboard." The dashboard will include infographics, data charts/tables, and text presenting information and strategies for prevention. For example, one strategy might be underscoring the importance of resilience as a mitigating factor for children who experience one or more adverse childhood experiences (ACEs). The dashboard would present data on the status of resilience of children in Hawaii, as well as descriptions of what programs are doing to build resilience in children.

Strategy 3: Raise awareness about the importance of safe and nurturing relationships to prevent child abuse and neglect.

The DOH MCHB, in partnership with the March of Dimes Hawaii Chapter, Healthy Mothers/Healthy Babies Coalition, the Maternal and Child Health Leadership Education in Neurodevelopmental Disabilities program, sponsored the 2019 Hawaii Fatality Summit. The Summit provided information on the role and work of the Child Death, Domestic Violence Fatality, and Maternal Mortality Reviews. The Summit included two violence topic tracks focusing on childhood adversity and domestic violence from a public health perspective. The Summit provided the opportunity to increase the awareness and knowledge about the three fatality reviews at one event to different stakeholders, and to understand common goals and strategies for possible future collaborative work especially in the area of CAN and domestic violence prevention.

Several community-based CAN prevention awareness events are currently underway across the islands. These include the promotion of *Wear Blue Day*, targeting businesses. Also, Ted Talk-like events called Keiki TALK will be held with business, policy-makers, community, and philanthropic leaders on topics such as toxic stress and the child's brain. While these events are generally specific to one day, community partners and organizers emphasize that CAN prevention and nurturing families should be an everyday priority.

Other events and activities aimed at raising awareness about safe and nurturing relationship/families incorporate the showing of the documentary *Resilience.* The film is shown to professional audiences and is followed by a facilitated discussion. Statewide media coverage on local TV and radio shows help to promote these events, and address concepts such as toxic stress and the brain, ACEs, and resilience. Speakers for these activities include: Dr. Sarah Enos Watamura, Associate Professor at the University of Denver and co-director of the Stress, Early Experience and Development (SEED) Research Center; Danny Goya, Program Director at Partners in Development which creates and implements programs to address the needs of at-risk groups within the Hawaiian community (e.g., preschool children, caregivers, and economically depressed neighborhoods); and Justina Acevedo-Cross, Program Director with the Hawaii Community Foundation.

Finally, the ECAS violence prevention communication campaign was launched during FY 2019. Three metaphors based on the concept of "serve-and-return," that promote positive interactions between parents and children, were field-tested using interviews with parents and other caregivers with young children. The metaphor that parents and caregivers identified with most was selected for the next phase of the campaign, that includes message and materials development, development of training materials, and planning for the referral to services.

Strategy 4: Provide community-based training and technical assistance promoting safe, healthy, and respectful relationships to prevent child abuse and neglect.

Strategy 4 will continue to be addressed through training events that serve to expand awareness and provide tools to support prevention within a specific population or context. Trainings and technical assistance events will continue to employ a summary and evaluation component to understand the composition of the training audience, the population served by attendees, and overall training effectiveness. Attendees are also queried regarding unmet or new training needs.

One of the upcoming trainings include "Preventing Early Childhood Toxic Stress in Hawaii Through a Trauma-Informed Response." Sarah Enos Watamura, Ph.D., Director of the Child Health and Development Laboratory at the University of Denver, and Mr. Danny Goya, Director of Development for the Partners in Development Foundation Hawaii, will present on the risks of toxic stress in the first three years of childhood, potential mitigating factors, the neurobiology of parents, having the difficult conversation with parents on ACEs, and promoting resiliency and hope. Links to resources and products will be also be available. Dr. Watamura will also conduct a half-day, by invitation, train-the-trainer event for internal and external DOH partners that work with young children.

Future training topics related to child maltreatment issues include safe sleep, ACEs, domestic violence, sex trafficking, and abuse of persons identifying as lesbian, gay, bisexual, transgendered, and queer or questioning (LGBTQ). ACEs and resilience trainings will be the major focus during this timeframe. Trainings will target audiences such as first responders, community-based organizations, the state Departments of Education and Human Services, and others as identified or via requests. The HHVP will continue to provide quarterly trainings to their contracted statewide service providers. FSVPS staff and other agency partners will continue to be invited. Finally, analysis of the assessment pertaining to special needs children will be completed during FY 2020, and results may demonstrate other training needs.

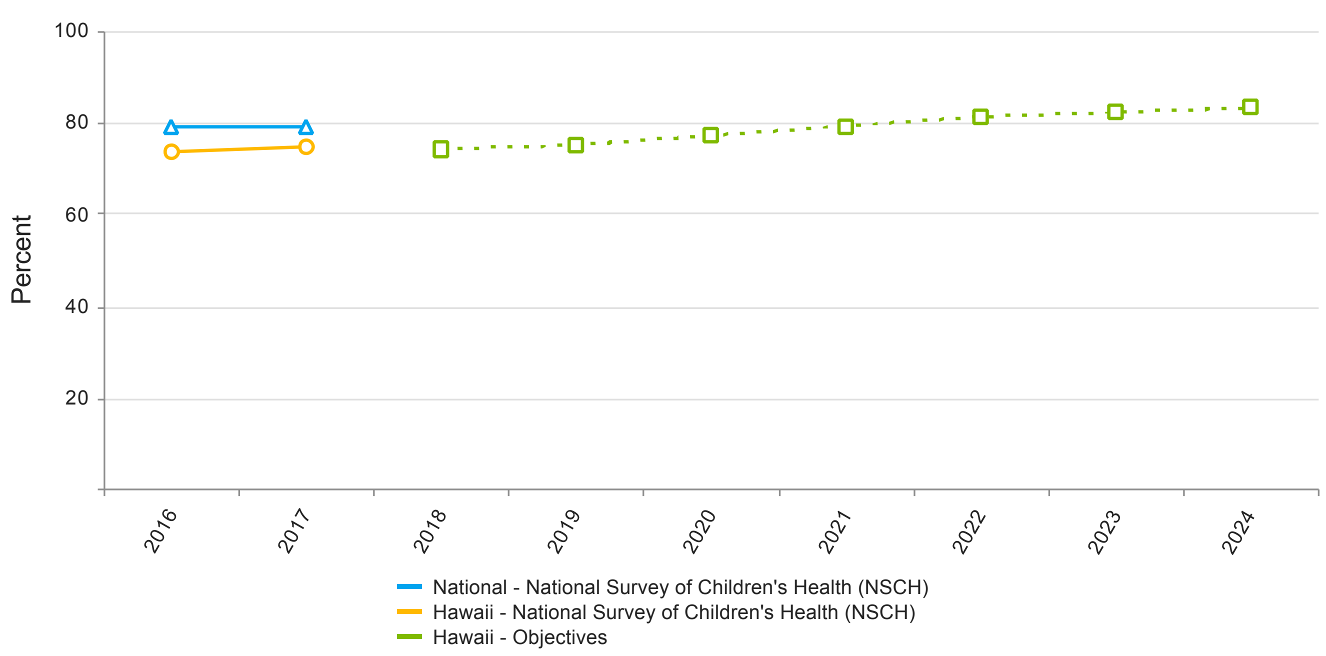
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2017	25.8	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2015_2017	11.0	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2015_2017	13.2	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016_2017	45.6 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	91.3 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016_2017	13.9 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	10.3 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2017	14.2 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2017_2018	61.0 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2017	69.4 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2017	84.8 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2017	85.9 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	19.1	NPM 10

National Performance Measures

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Indicators and Annual Objectives



Federally Available Data

Data Source: National Survey of Children's Health (NSCH)

	2016	2017	2018
Annual Objective			74
Annual Indicator		73.5	74.6
Numerator		67,325	74,226
Denominator		91,592	99,470
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives

	2019	2020	2021	2022	2023	2024
Annual Objective	75.0	77.0	79.0	81.0	82.0	83.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Development and dissemination of a teen-centered, Adolescent Resource Toolkit (ART) with corresponding continuing education series (Science) to primary care providers to increase knowledge and skill in implementing the adolescent well-care visit

Measure Status:	Inactive - Completed		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective			16
Annual Indicator			
Numerator	13	16	17
Denominator	51	51	51
Data Source	ART and Science Workgroup	ART and Science Workgroup	ART and Science Workgroup
Data Source Year	2016 PRog	2017	2018
Provisional or Final ?	Final	Final	Final

ESM 10.2 - Develop and disseminate a teen-centered, Adolescent Resource Toolkit (ART) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits

Measure Status:	Active				
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	18.0	23.0	25.0	28.0	30.0

State Action Plan Table

State Action Plan Table (Hawaii) - Adolescent Health - Entry 1

Priority Need

Improve the healthy development, health, safety, and well-being of adolescents

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

By July 2020, increase the percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year to 77% (Baseline: 2011-2012 NSCH data 82.2%)

Strategies

Collaboration. Develop partnerships with community health and youth service providers to promote adolescent health and annual wellness visits.

Engagement. Work with adolescents and youth service providers to develop and disseminate informational resources to promote access to adolescent preventive services.

Workforce Development. Provide resources, training, and learning opportunities for adolescent caregivers, community health workers, and other service providers to promote teen-centered, annual wellness visits.

ESMs	Status
ESM 10.1 - Development and dissemination of a teen-centered, Adolescent Resource Toolkit (ART) with corresponding continuing education series (Science) to primary care providers to increase knowledge and skill in implementing the adolescent well-care visit	Inactive
ESM 10.2 - Develop and disseminate a teen-centered, Adolescent Resource Toolkit (ART) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits	Active

NOMs

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

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

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

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

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

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

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

NPM-10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Introduction: Adolescent Wellness Visits (AWVs)

For the Adolescent Health domain, Hawaii selected NPM-10 (preventive medical visits) based on the results of the 2015 five-year needs assessment. Aggregated data from the 2016-17 National Survey on Child Heath (NSCH) show the estimate for Hawaii (74.6%) was similar to the national average of 78.7%. The annual FY 2018 objective (74%) was met.

Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits. In particular, adolescents with chronic health problems take on a greater role in managing those conditions. Therefore, adolescence is a time to empower, educate, and engage teens to establish health behaviors that will lay the foundation for their health into adulthood.

Nationally, Adolescent Wellness Visits (AWV) are recognized as an important standard of care. The *Bright Futures* guidelines recommend that adolescents have an annual checkup starting at age 11. The visit should cover a comprehensive set of preventive services, such as a physical examination, discussion of health-related behaviors, and immunizations.

Key disparities exist for accessing preventive care among Hawaii's adolescents. NSCH data show that parents graduated from college were more likely to have their adolescents seen for a preventive visit (83.5%), compared to those with some college (69.6%) or had only a high school education (66.4%). Rates for parents with less than a high school education were not reported, due to small numbers. Similarly, adolescents who lived in households with higher income (>=400% the federal poverty level [FPL]) were more likely to have had a preventive visit (86.1%), compared to those at 200-399% of the FPL (74.2%), those at 100-199% of the FPL (59.4%), and those below 100% of the FPL (65.5%). Finally, t adolescents living in a household where a non-English language was spoken had lower estimates (51.1%) of preventive medical visits, compared to those where English was the primary language spoken (77.0%).

The 2017 Hawaii Youth Risk Behavior Survey (YRBS) showed 47.9% of middle school-aged adolescents and 65.9% of high school teens reported seeing a doctor for a check-up or preventive physical exam. These are slight increases since 2015: 2% for middle school, and 4% for high school teens. These numbers may be overstated if adolescents defined sports physicals as a wellness visit. Within these data, neighbor island disparities remain. Kauai County middle and high school youth reported the lowest percentages of adolescent wellness visits, followed by Maui County and Hawaii County.

Focus groups with Hawaii youth conducted as part of the 2015 needs assessment revealed that teens have an alarmingly low awareness of the importance of preventive health care. Many do not know their primary care provider, and few have made a doctor's appointment on their own.

The FHSD Adolescent Health Unit (AHU) in the MCH Branch is the lead for the AWV measure. The AHU also administers the Personal Responsibility Education Program grant and assists with management of the state-funded perinatal support service contracts. The AHU coordinator is Title V funded.

The AHU revised the strategies for this measure to refocus program efforts beyond working with primary care physicians to improve the quality of the AWV, to working with a broader range of safety net service contractors such as the community health centers (CHCs) and youth service agencies, to better target at-risk adolescents. To address geographic disparities, the AHU is working with neighbor island CHC healthcare workers and youth service providers to promote adolescent health and annual wellness visits in underserved communities. Community health workers (CHWs) are ideal partners to provide prevention education and link youth to medical services as part of their outreach activities. Healthcare staff within the clinics can also integrate adolescent prevention care as part of athletic evaluations or chronic disease management (e.g., screening for risk behaviors and disease, assessing reproductive health concerns using One Key Question®, updating of immunizations, offering health guidance, etc.). Providers at youth service agencies can also promote adolescent wellness through education, asking simple screening questions, and encouraging AWV.

Coordination with NPM-12: Transition to Adult Health Care

Hawaii elected to continue work on the state priority to improve the percentage of youth with special health care needs (YSHCN), ages 14-21 years, to make a successful transition to adult care. The national performance measure for transition services addresses both youth with and without special needs. Therefore, the Title V AHU is

coordinating efforts with the CSHN program to address both adolescent health performance measures.

Strategies to address the NPM for adolescent preventive visits are discussed below.

Strategy 1: Collaboration. Develop partnerships with community health and youth service providers to promote adolescent health and annual wellness visits.

In FY 2018 the AHU refocused its efforts to target adolescents and youth service providers, rather than primary care physicians, when a key partnership with the Hilopaʻa Family to Family Information Center (F2FHIC) ended due to the loss of critical staff. Throughout FY 2018, the AHU sought input from community-based service providers, advocates, and teens to revise its strategies. To reach at-risk youth, the AHU leveraged existing contract partners including the community health centers (CHCs), particularly those on the neighbor islands, since teens in these counties have the lowest rates of AWV (per state YRBS data). Many of the CHCs are contracted by Title V programs to provide services such as perinatal support, family planning, primary care, WIC, and home visiting. Based on feedback received, it was decided to continue development of an Adolescent Resource Toolkit (ART); however, the toolkit is now geared toward allied healthcare professionals, youth service providers, and teens themselves.

During and upon completion, the ART will be shared with state youth organizations and stakeholders for review and input. Primary youth program partners include those funded by the federal Personal Responsibility and Education Program (PREP) teen pregnancy prevention program, the Hawaii Youth Correctional Facility (HYCF), and the Hale Mohalu Detention Home (DH). Other collaborators include the Hawaii Youth Services Network, Office of Youth Services, and numerous health prevention programs for youth including the Underage Drinking Prevention Program, the Youth Tobacco prevention coalition, Chronic Disease school wellness programs, and the suicide prevention coalition.

Title V forged an important partnership with the Hawaii Health Survey committee which consists of representatives from the Department of Education, the University of Hawaii, Office of Hawaiian Affairs, and DOH. The committee provides broad oversight for the administration of the YRBS. The most recent Middle and High School YRBS were administered during the 2017 spring semester. The question, “When was the last time you saw a doctor or nurse for a check-up or physical exam when you were not sick or injured?” is an important measure for AWV from the perspective of teens. The only county that showed a slight decrease (0.9%) was Hawaii County. Recent efforts to enhance the study’s sample size will allow for more detailed analysis of risk/protective behaviors with respect to demographic variables.

Strategy 2: Engagement. Work with adolescents and youth service providers to develop and disseminate informational resources to promote access to adolescent preventive services.

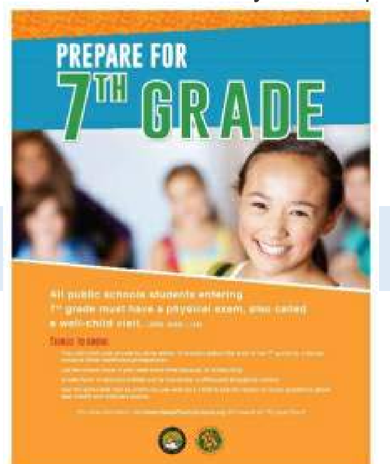
The Adolescent Resource Toolkit (ART) remains AHU’s primary vehicle for information dissemination to the community. In FY 2018 the AHU refined the ART with adolescents in mind, using input from teens as well as youth service providers. The AHU worked closely with the PREP teen pregnancy prevention programs to collect input from youth to identify health topics of interest, and determine how best to present the information with respect to language and engaging design elements. The Youth Challenge Academy’s 250 teens were also surveyed for input on the ART.

The ART now aims to inform teens and their families about critical health information needed to access healthcare services and includes: contact information to access care, the benefits of an AWV, age-of-consent and other access-to-care laws pertinent to adolescents, their rights to privacy and access to care (e.g., mental health, confidentiality of medical records, and accessing family planning services and emergency contraception for those 14 years and older), and general health information. Through partnering with the FHSD CSHN program’s Transition Workgroup, the ART now includes information to develop the adolescent’s confidence to access health care services and strengthen independent life skills.

The ART’s physical format evolved into a mix of printed cards, pamphlets, and materials that are geared for the adolescent audience. Currently, the ART is disseminated through a “warm hand-out” strategy, providing the printed resource materials assembled so they can be easily shared with youth. Exploration of other formats are being discussed with teens and providers. For example, the AHU is considering website development as a possible dissemination option with adequate technical assistance and resources.

The AHU forged partnerships with allied agencies and collaboratives to expand the ART's content, and facilitate dissemination of other heath messages and information. Through the Hawaii Maternal and Infant Health Collaborative (HMIHC), the AHU learned about the *SafeSex808* online resources aimed at teens and young adults to reduce the cases of sexually transmitted disease and unintended pregnancies. Spearheaded by the University of Hawaii John A. Burns School of Medicine (JABSOM), *safesex808.org* is an interactive reproductive health website, complete with an on-line "talk to a nurse" feature. JABSOM noted that the "talk to a nurse" feature is utilized minimally; however, queries on the website clearly indicate a need for medically accurate information. The website was incorporated into the ART.

In 2016, the Legislature passed Act 185 which requires all youth entering the 7th grade to have a physical examination. The DOH's Chronic Disease and Health Promotion Division (CDHPD) helped lead the effort to pass Act 185, and currently convenes a broad group of stakeholders to promote AWV. Information on the law is included in the ART. In the second year of implementation, the public messaging campaign to youth and families continued with the Department of Education's (DOE) and DOH's public service announcements playing through various media channels. The CDHPD reported that of the 13,150 public school teens entering the 7th grade in the 2018 – 2019 school year, 6,477 (49.3%) received physical exams. This was a 2% increase from the previous year's rate (47.8%). The AHU will work with health centers to increase these numbers in the coming year.



Strategy 3: Workforce Development: Increase resources, training and practice improvement support for adolescent health providers to provide teen-centered, well-care visits that align to Bright Futures.

Staff training on positive youth development and the protective factors began at the Kapolei adolescent detention center (DC) and the Office of Youth Services (OYS) Hawaii Youth Correctional Facility (HYCF). The ART materials are incorporated into the trainings.

The AHU is also working with the DOH family planning section to train adolescent service providers and parents to utilize One Key Question® to start a preventive health conversation with youth. Participants are trained to ask the question, "Would you like to become a parent in the next year?". Regardless of the answer, the recommendation is to encourage the teen to schedule an AWV if they did not have one in the last twelve months.

Evidence-Based/Informed Strategy Measure

The Evidence-Based/Informed Strategy Measure (ESM) selected for adolescent wellness was originally ESM 10.1 (Development and dissemination of a teen-centered, Adolescent Resource Toolkit [ART] with a corresponding adolescent health self-care wellness series to increase knowledge and skill in implementing the adolescent well-care visit). A data collection form was developed to track progress of the NPM workplan. As of FY 2018, 17 out of 51 elements had been completed. As discussed above, this measure will be inactivated since the strategy has changed to focus on adolescents and community providers.

A new ESM-10.2 was developed to reflect the revised strategies. Like ESM 10.1, the new measure uses a scale to track progress on the development and dissemination of the new iteration of the ART. Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 30. Scoring is completed by Title V AHU staff with input from key stakeholders. Baseline data for FY 2018 is 9 out of 30 points (or 30%). Objectives have been set through 2024. The completed data collection form is below.

Element	0 Not Met	1 Partially met	2 Mostly met	3 Completely met
Strategy 1: Collaboration				
1. Convene community teams to introduce the Adolescent Resource Toolkit (ART) “warm hand-out” strategy and develop the dissemination plan.		X		
2. Introduce CSHN’s “Footsteps to Transition” to contractors and outreach staff to utilize the infograph to show participants where they are in their transition to adulthood and to direct the warm handout conversation to the topic area needed.		X		
3. Update the listserv of adolescent health stakeholders and if available, collect adolescent developed handouts for incorporation into the ART.			X	
4. Develop a local base of speakers on issues affecting adolescent behaviors.		X		
Strategy 2: Engagement: Adolescent Resource Toolkit (ART)				
5. Test the Footsteps to Transition and ART materials with teen informants and outreach workers/educators as well as the “warm hand-out” dissemination approach.	X			
6. Conduct informant groups to determine adolescent awareness of the AWV and the perceived barriers to accessing an AWV.	X			
7. Assess service provider and informant information to assure the ART will provide useful health and resource information that will meet the needs of adolescents.		X		
Strategy 3: Workforce Development Training for Community Stakeholders				
8. Maximize opportunities to inform internal direct service providers and community stakeholders regarding AWV visits, the warm hand-out strategy, and the ART.		X		
9. Utilize the listserv to inform the work of lead adolescent health advocates regarding webinars, in-person training opportunities and other adolescent resources to include: positive youth development, teen pregnancy prevention, mental health first aid, gender orientation and the benefits of AWVs.			X	
10. Assess stakeholders for increased knowledge and comfort level post training.	X			
Total Points		**9**		

A logic model was developed for NPM-10 to review alignment among strategies, activities, measures, and desired outcomes. By working on the three strategy areas, Hawaii plans to increase the percentage of adolescents who had a preventive medical visit. The strategies are derived from guidelines from the national Office of Adolescent Health’s Think, Act, Grow (TAG) Call to Action designed to promote adolescent health through a comprehensive approach with varied stakeholders including parents, professionals, businesses, policymakers, and adolescents themselves.

ADOLESCENT HEALTH – LOGIC MODEL (effective FY20)
FAMILY HEALTH SERVICES DIVISION
HAWAII STATE DEPARTMENT OF HEALTH

RESOURCES

Hawai'i State Department of Health (HSDOH)
- Family Health Services Division & larger Hawai'i State Department of Health
- HART Steering Committee
- Other HSDOH branches

Hawaii's families, children, parents, and communities

Local partners, including:
- Community partners – Hilopa'a Family to Family Information Center, American Academy of Pediatrics (AAP)-HI Chapter, Hawaii Maternal & Infant Health Collaborative, YRBS Data Committee

National partners and strategies:
- Federal partners – Health Resources and Services Administration (Title V, Maternal and Child Health Bureau, associated data sources), Association of Maternal and Child Health Programs (AMCHP)

→

STRATEGIES & ACTIVITIES

Strategy 1 – Collaboration – develop partnerships with community stakeholders to promote adolescent health and well care visits.
- Partner with community agencies and workgroups that implement and advocate for programs and policies that promote adolescent health.

Strategy 2 – Engagement – work with adolescents and youth service providers to develop and disseminate informational resources to promote access to adolescent preventive services.
- Hawaii Adolescent Resource Toolkit (ART) – test toolkit with youth and providers, disseminate to the community.

Strategy 3 – Training and Workforce Development – provide resources, training, and learning opportunities for learning opportunities for adolescent caregivers, community health and youth servide providers to promote teen-centered, well-care.

→

SHORT-TERM OUTCOMES

Evidence-Based/Informed Strategy Measures
- Development/dissemination of ART for medical providers [ESM 10.1 Inactive].
- Development/dissemination of ART for adolescents, community health workers and youth service providers [ESM 10.2].

↓

Other Short-Term Outcomes Expected
- Community providers and stakeholders increase knowledge and skill in promoting and implementing adolescent well-care visits, and supporting overall adolescent health.
- Adolescents and families increase awareness and empowerment in achieving good health.

→

LONGER-TERM OUTCOMES

National Performance Measure
- Percent of adolescents (12-17) with preventive medical visit in the past year [NPM 10].

↓

National Outcome Measures
Increased access to preventive services, such as:
- Increase of children with mental/ behavioral condition who receive treatment or counseling [NOM 18].
- Increase in children who are vaccinated for influenza [NOM 22.2], HPV [NOM 22.3], Tdap [NOM 22.4], and meningitis [NOM 22.5].

↓

Longer term outcomes expected
- Decrease of children who are overweight or obese [NOM 20].
- Increase of children in good health [NOM 19].
- Reduction of adolescent mortality [NOM 16.1], including motor vehicle mortality [NOM 16.2] and suicide [NOM 16.3].

CONTEXTUAL CONDITIONS
Socio-economic status, rurality, cultural considerations, language and health literacy, etc.

Version 7//19

Challenges, Barriers

Due to changes in organizational resources, work with primary care providers is no longer the main focus. The AHU's strategies were revised based on input from adolescents and community service providers working with at-risk youth. The ART will be used to promote positive health behaviors including lifestyle factors (e.g. physical activity), encourage youth to take greater responsibility for their health decisions, and link youth to health services (e.g., AWVs).

Many adolescents only access care for illness or to secure clearance for athletic program participation. Adolescents and their family members may equate a sports physical to an AWV. Hawaii's shortage of primary care providers, particularly on the neighbor islands and parts of rural Oahu, may also impact access to wellness care for adolescents. New players in the health care market like 'minute clinics' and urgent care centers also pose new challenges to AWVs. Busy families use these convenient community-based options as a primary source of care which can undermine the benefits of the more comprehensive AWV provided by the medical home.

Current federal healthcare reform proposals have created uncertainty for health plans and health care providers in terms of prioritizing preventive services as a major cornerstone for positive health. Greater effort is needed to promote wellness care and address barriers to access while health insurance coverage remains available.

Overall Impact

The passage of Act 185 requires all youth entering the 7th grade to have a physical examination, and is a policy-level effort to address the unique needs of adolescents during wellness visits. This policy is in year two of its implementation. Data collected by DOH showed there was a 1.5% increased compliance (from 47.8% percent to 49.3%) among Hawaii's 52 public middle schools. Two schools achieved 100% compliance (Olomana and Paauilo Elementary and Intermediate). Individual school compliance data will continue to be tracked and shared with communities to increase promotion of AWVs.

NPM-10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Families and adolescents themselves should know the many benefits of the adolescent wellness visit (AWV), and how to access and maximize AWVs. Therefore, moving forward, the Adolescent Health Unit (AHU) revised its strategies to focus on:

- Collaboration with community health and youth service providers to promote adolescent health and annual wellness visits.
- Engagement with adolescents and youth service providers to develop and disseminate the Adolescent Resource Toolkit (ART).
- Workforce Development training and technical assistance that will target health clinic staff and other community caregivers to distribute the toolkits in various settings (e.g., schools, clinics, community health fairs, etc.), and coach teens to utilize the annual well visit.

Plans to implement the strategies for FY 2020 are described.

Strategy 1: Collaboration. Develop partnerships with community health and youth service providers to promote adolescent health and annual wellness visits.

Title V will partner with community agencies and workgroups that implement and advocate for programs and policies that promote adolescent health. This will include community health center outreach staff who promote annual wellness visits and adolescent health through school and community venues. Outreach activities will include addressing positive health through self-care and connections with supportive people.

Specific activities planned for this fiscal year include:

- Convene community teams to introduce the Adolescent Resource Toolkit (ART) “warm hand-out” strategy and develop the dissemination plan.
- Introduce CSHN’s “Footsteps to Transition” to contractors and outreach staff to utilize the infograph to show participants where they are in their transition to adulthood and to direct the warm handout conversation to the topic area needed.
- Update the listserv of adolescent health stakeholders and if available, collect adolescent developed handouts for incorporation into the ART.
- Develop a local base of speakers on issues affecting adolescent behaviors.

Strategy 2: Engagement. Work with adolescents and youth service providers to develop and disseminate informational resources to promote access to adolescent preventive services.

The revised ART focuses on building adolescent knowledge, behavior, and skills to access health care and community resources. By reaching youth where they are in their transition to adulthood, health educators and outreach staff will be able share at least one local resource and/or connect them to a health center that is appropriate for their stage of development. The “warm hand-out” of information by community outreach professionals has been deemed most effective to deliver the materials, as well as empower youth to make informed decisions about their health and well-being. This approach, where information is delivered during a two-way in-person interaction (as opposed to passive or one-way dissemination), will also build relationships between the adolescent and adult/organization.

The revised ART focuses on building adolescent knowledge, behavior, and skills to access health care and community resources. By reaching youth where they are in their transition to adulthood, health educators and outreach staff will be able share at least one local resource and/or connect them to a health center that is appropriate for their stage of development. The “warm hand-out” of information by community outreach professionals has been deemed most effective to deliver the materials, as well as empower youth to make informed decisions about their health and well-being. This approach, where information is delivered during a two-way in-person interaction (as opposed to passive or one-way dissemination), will also build relationships between the adolescent and adult/organization.

Specific activities planned for this fiscal year include:

- Test the Footsteps to Transition and ART materials with teen informants and outreach workers/educators as

well as the "warm hand-out" dissemination approach.
- Conduct informant groups to determine adolescent awareness of the benefits of an AWV and their perceived barriers to accessing care; and
- Assess service provider and informant information to assure the ART will provide useful health and resource information that will meet the needs of adolescents.

Community health center partners will be asked to increase the number of 7th grade entry physical examinations at the beginning of the school year that integrate ART materials. The intent is to connect teens to caring adults, specifically at a local health clinic/primary care provider and encourage them to take charge of their own health.

The AHU will work with the CSHN section to engage Youth with Special Health Needs and their families to collect input on the ART. Possible avenues for input include CSHN program clients and/or Transition events hosted annually by the Department of Education.

Strategy 3: Workforce Development. Provide resources, training, and learning opportunities for adolescent care givers, community health workers, and other service providers to promote teen-centered, annual wellness visits.

Facilitators from the Teen Outreach Program (TOP), staff members at the Hawaii Youth Correctional Facility (HYCF) and the Hale Mohalu Detention Home (DH), and other community caregivers will receive adolescent health presentations that will include: positive youth development, motivational interviewing, gender orientation, and trauma-informed care. Inclusion of these audiences is intended to spark a culture shift from punitive to restorative care for vulnerable adolescents that enter the juvenile justice system.

Specific activities planned for this fiscal year include:
- Maximize opportunities to inform internal direct service providers and community stakeholders regarding AWV visits, the warm hand-out strategy, and the ART.
- Inform the work of lead adolescent health advocates regarding webinars, in-person training opportunities and other adolescent resources to include: positive youth development, teen pregnancy prevention, mental health first aid, gender orientation and the benefits of AWVs.
- Assess stakeholders for increased knowledge and comfort level post training.

The AHU will also continue work with the DOH Family Planning Program to train adolescent service providers and parents to use One Key Question® to start a preventive health conversation with youth. The question, "Would you like to become a parent in the next year?" is recommended. Regardless of the answer, one of the recommended actions would be to schedule an AWV if they did not have one in the last twelve months.

The revised Data Collection Form that lists the new 10 strategy components will be completed and the indicator reported for next year.

Title V Adolescent Health Programs

Adolescent Health programs administered by the Hawaii Title V program include:

Adolescent Wellness: spans across the physical, mental, and social emotional aspects of adolescents and young adults 10 to 24 years of age. Concentration on high school graduation, sexual health, positive youth development, and transitioning into adulthood.

Personal Responsibility Education Program (PREP): the purpose of the grant is to fund evidence-based programs that educate youth on abstinence and contraception for the prevention of pregnancy, sexually transmitted infections, and HIV/AIDS, which includes decision-making, self-regulation, and other adulthood preparation subject areas. This program targets services to high-risk, vulnerable and culturally underrepresented youth populations between the ages of 10 and 19. Hawaii funds are used to implement the Teen Outreach Program (TOP) curriculum at the Youth Challenge Academy residential on facilities on Oahu and Hawaii island, and the Kawailoa Youth and Family Wellness Center (formerly known as the Hawaii Youth Correctional Facility). Both facilities serve higher risk youth.

Child Abuse and Neglect, Domestic and Sexual Violence Prevention: these programs are committed to the primary prevention of all forms of violence, stopping violence before it begins so that all people, families, and communities are safe, healthy, and free of violence. Together known as The Family Strengthening & Violence Prevention Unit, staff and partners provide programs statewide for the prevention of child abuse and neglect, sexual violence, and domestic violence. Activities also include support for parents and provision of education targeted for teens to prevent sexual violence.

Child Death Review: statewide surveillance system for deaths among children ages 0-18 years. Aims to reduce preventable deaths to infants, children, and youth, through multidisciplinary interagency reviews.

Maternal Mortality Review: statewide maternal mortality surveillance reviews that identify gaps in the health care system and social services, challenges with health care access and quality (especially prenatal and perinatal care), and ways to improve the health, health behaviors, and health care of women before and during pregnancy.

Family Planning Services: assists individuals in determining the number and spacing of their children and promotes positive birth outcomes and healthy families. Education, counseling, and medical services are available through federal- and state-funded clinical programs including programs targeting adolescents. The program provides leadership for the implementation of One Key Question® (OKQ) – "would you like to become pregnant in the next year?" OKQ supports reproductive life planning, decreases unplanned pregnancies, and promotes healthy birth outcomes.

Perinatal Support Services: community health clinics statewide provide case-managed support services and resources for high-risk pregnant women and teens to increase the likelihood of positive birth outcomes. Objectives include: increasing annual wellness visits; early prenatal care; decreasing incidence of preterm, low, and very low birth infants; and improving the health of participants.

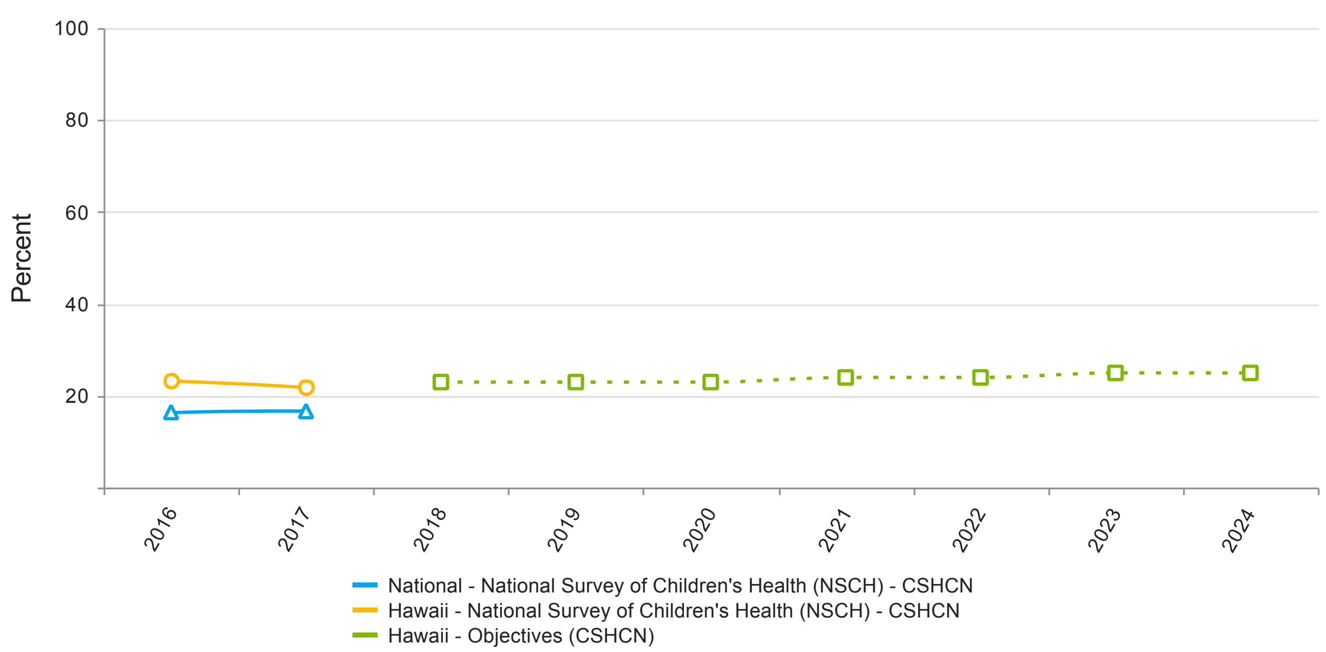
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016_2017	17.4 %	NPM 12

National Performance Measures

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	**2017**	**2018**
Annual Objective			23
Annual Indicator		23.3	21.9
Numerator		4,235	4,457
Denominator		18,144	20,375
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	23.0	23.0	24.0	24.0	25.0	25.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult health care for Youth with Special Health Care Needs (YSHCN), related to Six Core Elements of Health Care Transition 2.0.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective			17
Annual Indicator			
Numerator	12	13	18
Denominator	33	33	33
Data Source	Title V Transition Workgroup	Title V Transition Workgroup	Title V Transition Workgroup
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	21.0	24.0	26.0	28.0	30.0	33.0

State Action Plan Table

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

Priority Need

Improve the percentage of youth with special health care needs ages 12-21 years who receive services necessary to make transitions to adult health care.

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

By July 2020, increase the percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care to 24% [Baseline: Hawaii 37.3%, National Survey of CSHCN (NSCSHCN) 2009/10]

Strategies

Incorporate transition planning into Children and Youth with Special Health Needs Section (CYSHNS) service coordination for CYSHNS-enrolled youths and their families.

Provide education and public awareness on transition to adult health care for children/youth with and without special health care needs, and promote the incorporation of transition into planning and practices, in collaboration with state and community partners.

ESMs	Status
ESM 12.1 - Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult health care for Youth with Special Health Care Needs (YSHCN), related to Six Core Elements of Health Care Transition 2.0.	Active

NOMs

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

NPM 12-Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Introduction: Transition Planning

For the Children with Special Health Care Needs (CSHCN) population domain, Hawaii selected NPM 12 transition to adult health care based on the results of the 5-year needs assessment. By July 2020, the state seeks to increase the percent of youth with (and without) special health care needs who received transition services to 24%. Data from 2016-2017 National Survey of Children's Health (NSCH) showed that the estimate for Hawaii's youth with special health care needs (YSHCN) (21.9%) was similar to the national estimate of 16.7%. The estimates for youth *without* special health care needs were the same in Hawaii (13.9%) and the nation (13.9%). There were no significant differences in reported subgroups by household income poverty level, nativity, race/ethnicity, sex, and household structure based on the single year 2016-2017 data.

Optimal health and adequate health care are important in making successful transitions. The majority of YSHCN do not receive needed support to transition from pediatric to adult health care. When compared to youth without special health care needs, YSHCN are less likely to complete high school, attend college, or be employed.

The focus on the transition of youth with and without special health care needs to adult health care continues to be a priority measure for Hawaii. The Children and Youth with Special Health Needs Section (CYSHNS) within the Hawaii Department of Health Children with Special Health Needs Branch (CSHNB) is the lead agency for this priority measure. For transition planning for all youth, with and *without* special health care needs, CYSHNS is collaborating with the Maternal and Child Health Branch (MCHB) Adolescent Health Program to integrate transition planning into Title V activities to promote adolescent wellness visits. Monthly transition meetings of the statewide transition team, including MCHB staff, are held through Zoom to ensure participation of the neighbor island staff.

Title V does not directly fund transition activities but does fund key CYSHNS staff including the Section Audiologist and Nutritionist, who provide leadership for the Transition team. In addition, Title V funds the CSHNB Chief, Research Statistician, and administrative staff who provide support to the Transition Team.

Professional, state, and community agencies and organizations in Hawaii actively support and promote the transition to adult life. The American Academy of Pediatrics-Hawaii Chapter priorities include the transition of adolescents to adult care with a focus on YSHCN. Hilopa'a Family to Family Health Information Center (F2FHIC) trains medical providers, professionals, and families statewide in transition planning. A statewide network of youth agencies and programs, which includes the Hawaii State Council on Developmental Disabilities and the Hawaii Department of Education (DOE), collaborate on annual transition events.

Upon enrollment in ninth grade, all DOE students begin their individualized Personal/Transition Plan (PTP) that charts their course from high school to post-secondary education and/or employment. Health care priorities can be included in the PTP as part of necessary supports to attain education or training goals. Students enrolled in DOE Special Education receive additional services from the Division of Vocational Rehabilitation to plan for education and employment beyond high school. Special Education students with health-related issues may receive transition assistance in the form of equipment and training needed for employment and post-secondary education.

The two strategies selected for NPM 12 are based on national best practices and recommendations. Progress on the strategies are described below.

Strategy 1: Incorporate transition planning into CYSHNS service coordination for CYSHNS-enrolled youths and their families.

CYSHNS transition efforts are guided by the *Got Transition's Six Core Elements of Health Care Transition 2.0* (http://www.gottransition.org/providers/index.cfm). The Six Core Elements are being integrated into CYSHNS's policy and procedures to support youth and their families in preparing for their transition to adult health care.

Transition Policy

The CYSHNS Transition Policy has been completed. It is posted on the CSHNB website, http://health.hawaii.gov/cshcn/home/communitypage/, and is being added to the CYSHNS program brochure for providers and consumers. CYSHNS is educating all staff on transition approach, policy, the Six Core Elements, and the role of CYSHNS, youth/family, and pediatric/adult health care team in the transition process, with consideration for cultural preferences. Information and updates to policy are provided at monthly meetings.

Tracking and Monitoring
CYSHNS established procedures for identifying and tracking youth enrolled in the program. Update of the data system began in 2018 and will track and monitor transition activity by alerting staff of the need to complete a scheduled transition activity. The data system will also qualify and quantify staff transition interactions and planning sessions with youth and families.

Transition Readiness
At least annually, beginning at age 12, CYSHNS staff began assessing transition readiness and progress with youth and their families, to identify needs related to the youth managing his/her health care. CYSHNS is finalizing the Transition Readiness Assessment Checklist (TRAC), adapted from the readiness assessment tool on *Got Transition*. The purpose of the TRAC is to assess the child's current readiness level for transition to adult health care and to identify future activities that will prepare the YSHCN to transition to adult health care. With input from youth and families, the TRAC is near completion. Changes to the TRAC were made to include a review of the youth's transition progress over the past year and the setting of transition goals for the coming year.

CYSHNS staff is finalizing a colorful handout titled *My Path to Adult Health Care* (PATH) which is a visual flowchart of activities to prepare and guide the youth for the transition to adult health care, adapted from *Got Transition*. The PATH promotes responsibility and self-advocacy in the areas of healthy habits, adult health care providers, medication, health insurance, and adult health care. It reminds families to allow youth to practice simple life skills early in order to build the youth's confidence and knowledge for more complex responsibilities as they mature. The PATH is being reviewed by providers and families before finalizing.

Transition Planning
At least annually, CYSHN staff in partnership with youth and families began updating their plan of care by administering the TRAC to review past goals and write new goals focusing on adult health care providers, health insurance, and personal responsibility. Transition planning has been incorporated in other CSHNB programs, including Hawaii Community Genetics Clinic, Early Language Working Group, and neighbor island cardiac, neurology, and nutrition clinics.

Transition Transfer of Care/Transition Completion
CYSHNS staff began assisting the youth and family for transfer from a pediatric health care system to adult health care providers, and in applying for health insurance coverage as an adult by providing guidance, resources, and training.

CYSHNS staff began assisting with referrals to partnering adult service agencies. CYSHNS is a participating agency in the state's No Wrong Door (NWD) program, which is an integrated person-centered system that supports individuals of all ages, disabilities, and payers. NWD's referral system provides a universal intake point for access to care. Each participating agency accepts and processes requests for services, then contacts and works with the appropriate agency to ensure that a link and handoff is made.

Progress: ESM 12.1 measures progress of CYSHNS work under Strategy 1. The rating scale has 11 strategy items, adapted from *Got Transition's Six Core Elements of Health Care Transition 2.0*. CYSHNS staff scores each item from 0-3, with a maximum total score of 33. For FFY 2018, the ESM score was 18 (55% completion), exceeding the annual target score of 17. The FY 2018 indicator shows progress over the past year of 5 points from the FFY17 indicator of 13 (or 39% completion rate of scale activities).

Data Collection Form – FFY 18 ESM 12.1: Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult health care for Youth with Special Health Care Needs (YSHCN), related to Six Core Elements of Health Care Transition 2.0. The scores below indicate the historical progress since 2016.				
	0 Not Met	1 Partially met	2 Mostly met	3 Completely met
Transition policy				
1. Develop a CYSHNS transition policy/statement, with input from youth, families, and providers, that describes the approach to transition, including consent/assent information.	*0* *2016*			***3*** *2017* **2018**

2. Educate all staff about the approach to transition, policy/statement, Six Core Elements, and roles of CYSHNS, youth/family, and pediatric/adult health care team in the transition process, taking into account cultural preferences.	*0* *2016*	*1* *2017*	**2** **2018**	
Transition tracking and monitoring				
3. Establish criteria and process for identifying and tracking transitioning youth in the CSHNP database.	*0* *2016*	**1** *2017* **2018**		
4. Utilize individual flow sheet or database to track youth's transition progress.		**1** 2016-17 **2018**		
Transition readiness				
5. At least annually assess transition readiness with youth and parent/caregiver using the TRAC, beginning at age 12, to identify needs related to the youth managing his/her health care (self-care).	*0* *2016*	*1* *2017*	**1.5** **2018**	
6. Jointly develop goals & prioritized actions with youth & parent/caregiver, & document in a plan of care in the TRAC.		*1* *2016-17*	**1.5** **2018**	
Transition planning				
7. At least annually update TRAC goals, in partnership with youth and families, including readiness assessment findings, goals, and prioritized actions.	*0* *2016*	**1** 2017 **2018**		
8. Prepare youth and parent/caregiver for adult approach to care before age 18, including legal changes in decision-making, privacy, and consent; self-advocacy; access to information; and insurance continuity.		*1* *2016-17*	**1.5** **2018**	
9. Develop and implement referral procedures to adult service agencies.		*1* *2017*	**2** **2018**	
Transition transfer of care				
10. Prepare youth and parent/caregiver for transferring to an adult health care provider and planning for health insurance coverage as an adult.		*1* *2017*	**1.5** **2018**	
Transition completion				
11. Contact youth and parent/caregiver, when CYSHNS services end, to confirm having an adult health care provider and health insurance coverage, or provide further transition guidance.		*1* *2017*	**2** **2018**	
	2018 TOTAL = 18 (55% completion)			

Strategy 2: Provide education and public awareness on transition to adult health care for children/youth with and without special health care needs, and promote the incorporation of transition into planning and practices, in collaboration with state and community partners.

This strategy is based on recommendations from national guidance and input with local stakeholders. The 2020 Federal Youth Transition Plan and other reports recommend close collaboration among providers working with transitioning youth and supporting quality professional development. The Centers for Medicare & Medicaid Services (CMS) 2014 report on *Paving the Road to Good Health* recommended developing partnerships among key stakeholders and creating adolescent-friendly material.

<u>Educational/Awareness Events</u>
CYSHNS continued multiple collaborations with stakeholders, including youth and family members, to conduct annual educational transition fairs and events. On Oahu, transition fair locations are rotated among the four DOE school districts. In 2018, the DOE Central District hosted the Footsteps to Transition Fair held at Radford High School with approximately 200 youth and their families in attendance. Hilopaʻa F2FHIC presented a session on the transition to adult health care. Over 40 agencies had display tables for the sharing of information. CYSHNS distributed the PATH and the *Student Supports in Higher Education* handouts to participants. Both handouts were well received.

CYSHNS participated in Special Parent Information Network (SPIN) as an advisory board member for its annual statewide conference held in March 2018. SPIN is a parent-to-parent organization that provides information, support, and referral to parents of children and young adults with disabilities and the professionals who serve them. Families from the neighbor islands were able to attend this Oahu event through sponsorship from SPIN and other agencies. Roughly 65 vendors and over 400 family members participated in this conference with speakers and workshops.

Other events on transition included the Special Olympics, Malama da Mind (Hawaii Island), Kauai's Legislative Forum, Kona's Marshallese Day, Healthy From Head to Toe, You Can't Have Inclusion Without Us, Parent Child Fair, and Keiki Steps. Transition issues were discussed with athletes, parents, and caregivers at the Healthy Hearing venue of the Hawaii Special Olympics Annual State Summer Games in May 2018, for which the CYSHNS Audiologist was a co-director.

In 2018, the CYSHNS Public Health Nutritionist provided educational opportunities for youth and young adults with inborn errors of metabolism to share low protein foods and recipes. This annual training included sharing information and resources on health care, employment, education, and navigating insurance issues regarding needed formula and supplies.

<u>Partnerships & Networking</u>
CYSHNS is connected to a broad network of government and community groups that help with systems coordination and advocacy for health care transition. Key planning partners include: MCHB Adolescent Health Program, DOE, SPIN, DOH Disabilities and Communication Access Board, DOH Developmental Disabilities, Division, NWD, Hawaii State Council on Developmental Disabilities, Hilopaʻa F2FHIC, Best Buddies Hawaii, Hawaii Maternal Child Health Leadership Education in Neurodevelopmental & Related Disabilities (MCH-LEND), Community Children's Council Office, and Division of Vocational Rehabilitation, and other organizations. Kauai, West Hawaii, and Hilo Legislative Disability Forums provide another opportunity to share transition messages.

<u>Educational Materials</u>
The CYSHNS Transition workgroup met monthly to develop high impact outreach material that can be understood across the literacy spectrum. Some at-risk groups are from the Federated States of Micronesia, Republic of the Marshall Islands, South America, and families with a parent or other family member who has a disability.

CYSHNS reviewed the Adolescent Resource Toolkit (ART) currently under development by the MCHB Adolescent Health Program. The ART is intended to provide health information for teens through various media forms with emphasis on the importance of adolescent wellness visits and planning for transition to adulthood and adult care.

Review of Action Plan
A logic model was developed for NPM 12 to review the alignment between the strategies, activities, measures and desired outcomes. By working on the following strategy areas, Hawaii aims to increase the percentage of adolescents who receive transition services to adult health care.

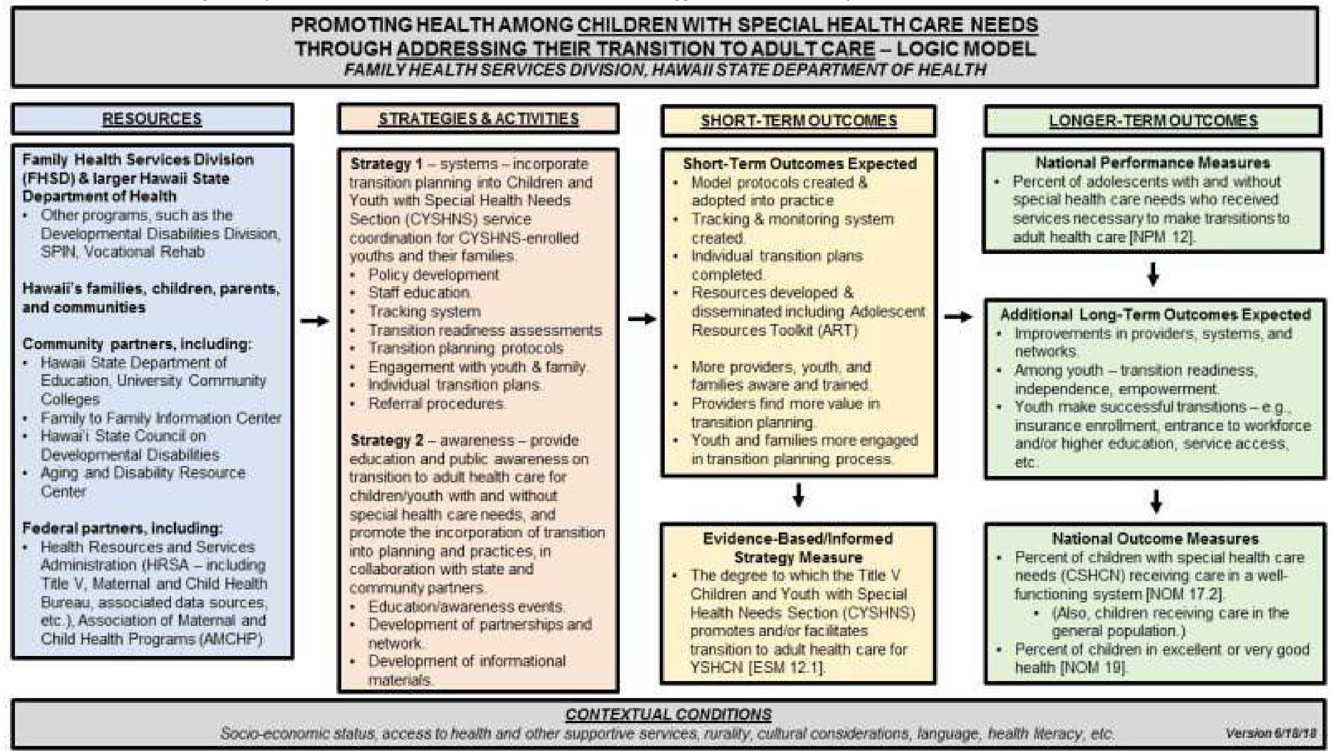
Strategy 1 focuses on integrating the *Got Transition's* Six *Core Elements of Health Care Transition 2.0* into CYSHNS service protocols to ensure that youth enrolled in CYSHNS and their families prepare for the transition to adult health care. This framework identifies the different planning components that need to be addressed. CYSHNS is developing and establishing a program system of standardized policy and procedures, materials, and data collection methods that can be used by other agencies, pediatric health care providers, and community groups

working with youth and transition.

Strategy 2 focuses on public health education and awareness based on national and local best practices. Through expanded partnerships, CYSHNS will reach more youth with and without special health care needs, providers, and families to support and participate in transition planning.

In addition to assuring continual improvements in the ESM 12.1 and NPM 12, long-term outcomes include:

- Improvement in transition services offered by providers, systems, and networks
- Among all youth – greater transition readiness, independence, empowerment
- Evidence of more youth making successful transitions to adult care – e.g., increase enrollment in health insurance plans, entrance to the workforce and/or higher education, and access to adult care



Challenges encountered

For Strategy 1, a major challenge was in developing a new database system for CYSHNS. Conversion from an old DOS system to a Microsoft Office Access database is nearing completion. The new database will be accessible to all CYSHNS staff, including those on the neighbor islands, increasing access. Staff will be able to generate reports, monitor and track transition practice, etc. Upon the addition of a section to track and monitor transition activity, the database will be complete.

For Strategy 2, a challenge was in identifying and establishing partnerships with adult health care agencies and providers in promoting the transition to adult health care for youth with and without special health care needs. To encourage greater collaboration across sectors, the challenge was to illustrate the clear benefits to shared client populations and to include youth without special health care needs.

Another challenge was to develop methods to measure the progress and effectiveness of health education and awareness activities. CYSHNS will research tools that will quantify and qualify outcomes.

Technical assistance was needed to design more effective messaging and outreach methods to youth including the use of social media and technology. The partnership with the MCHB Adolescent Health program will help address this concern by utilizing their ART and connecting with their network of youth service partners.

Overall impact

Over the past 7 years, progress was made to build a system of service providers and agencies to help Hawaii youth transition to adulthood. CYSHNS is integrating transition planning into its services and helping to promote the

message publicly in partnership with community programs and agencies. The transition workbook, TRAC and PATH developed by CYSHNS is being used to track and document life goals, including health care for youth enrolled in CYSHNS. These resources have also been adopted by DOE, pediatricians, and the military health care system and is part of their planning for transition to adult health care.

CYSHNS continues to provide leadership and partner with state and community groups through annual *Footsteps to Transition* fairs and other events on Oahu and the neighbor islands. Since the inception of Maui's first transition fair, events are held annually across all counties and have expanded to include a comprehensive array of services and educational providers. In partnership with the DOE, the Transition Fairs have created other outreach and educational events for public and adult health care providers, as well as workforce training events for providers.

NPM 12-Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Strategy 1: Incorporate transition planning into CYSHNS service coordination for CYSHNS-enrolled youths and their families.

Transition policy
- Amend the transition policy to add privacy and consent
- Continue to include transition to adult health care in all aspects of CYSHNS services to make it a familiar and friendly concept
- Continue educating CYSHNS staff regarding policy and procedures for transition

Transition tracking and monitoring
- Develop procedures for using the TRAC to track and monitor the progress of transition activities, and the quality and quantity of CYSHNS staff interactions
- Complete the upgrade of the CYSHNS client database to an Access system and provide access to the new Access system to all CYSHNS staff, including those on the neighbor islands

Transition readiness
- Revise the PATH and TRAC and develop guidelines and talking points
- Obtain feedback from youths and families in reviewing various assessment and planning tools

Transition planning
- Develop procedures and talking points for using the TRAC and PATH as part of the youth's transition planning process
- Develop a system for receiving referrals to CYSHNS program for assistance with transitioning to adult health care
- Continue participation in the NWD network of agencies

Transition transfer of care
- Continue work toward helping CYSHNS-enrolled youth and families prepare for adult health care

Transition completion
- Research ways of ensuring completion of transition, and ways of documenting and quantifying completion
- Develop a scorecard or survey to give to the adult health care provider to verify transition completion

Strategy 2: Provide education and public awareness on the transition to adult health care for children/youth with and without special health care needs and promote the incorporation of transition into planning and practices, in collaboration with state and community partners.

In March 2019, a cohort of five employees from CSHNB and MCHB attended a 4-day training at the National MCH Workforce Development Center in North Carolina. Training was provided in evidence-based/informed tools for developing meaningful ESM's and for tracking and monitoring progress in meeting the ESM's. On-going technical assistance is provided through monthly webinars, consultation, and peer coaching with the MCH Workforce staff. A Hawaii-based coach is also assigned to the cohort, who is available for guidance and mentorship in completing a project related to transition to adult health care.

CYSHNS will continue involvement in outreach and education events for children with and without special health care needs and their families. The events include the DOE-hosted Transition Fairs, annual statewide SPIN Conference, Special Olympics, Malama da Mind, legislative forums, Marshallese Day, Healthy From Head to Toe, You Can't Have Inclusion Without Us, Parent Child Fair, and Keiki Steps.

CYSHNS will partner with the MCHB Adolescent Health Program to increase outreach to all adolescents, with and without special health care needs.

CYSHNS will revise the TRAC and PATH to include information on the transition to adult health care for children without special health care needs and to include the importance of having a medical home and wellness visits.

Title V CSHCN Programs

Children with Special Health Needs Branch (CSHNB) is working to assure that all children and youth with special

health care needs (CSHCN) will reach optimal health, growth, and development. Programs include:

Birth Defects: provides population-based surveillance and education for birth defects in Hawaii and monitors major structural and genetic birth defects that adversely affect health and development.

Childhood Lead Poisoning Prevention: reduces children's exposure to lead by strengthening blood lead testing and surveillance, identifying and linking lead-exposed children to services, and improving population-based interventions. Program is funded by the Centers for Disease Control and Prevention (CDC).

Children and Youth with Special Health Needs: provides assistance with service coordination, social work, nutrition, and other services for children with special health care needs age 0-21 years with chronic medical conditions. It serves children who have or may have long-term or chronic health conditions that require specialized medical care and their families.

Early Childhood: focuses on systems-building to promote a comprehensive network of services and programs that helps promote children with special health needs and children who are at risk for chronic physical, developmental, behavioral, or emotional conditions to reach their optimal developmental health.

Early Intervention Section: provides early intervention services for eligible children age 0-3 years with developmental delay or at biological risk, as mandated by Part C of the Individuals with Disabilities Education Act. Services include care coordination; family training, counseling, home visiting; occupational therapy; physical therapy; psychology; social work; special instruction; and speech therapy. Parents/caregivers are coached on how to support the child's development within the child's daily routines and activities.
Genetics Services: provides information and education about topics in genetics statewide and services to neighbor island families.

Hiʻilei Developmental Screening: is a free resource for parents of children from birth to 5 years old. Program provides developmental screening via a mail or online screen; activities to help a child develop; referrals for developmental concerns; and information about state/community resources.

Newborn Hearing Screening: provides newborn hearing screening for babies as required by Hawaii state law to identify hearing loss early so that children can receive timely early intervention services.

Newborn Metabolic Screening: provides newborn blood spot testing for babies as required by Hawaii state law. The tests help detect rare disorders that can cause serious health, developmental problems and even death if not treated early.

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective			11
Annual Indicator			
Numerator	8	11	12
Denominator	72	72	72
Data Source	Telehealth work group, Family Health Services Divi	The preliminary 5-year plan objectives were develo	Telehealth work group, Family Health Services Divi
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	13.0	14.0	15.0	16.0	17.0	18.0

State Action Plan Table

State Action Plan Table (Hawaii) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Improve access to services through telehealth

SPM

SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers.

Objectives

By July 2020, 100% of Title V programs use telehealth to provide services, education, and/or training.

Strategies

Telehealth infrastructure development: - Recruit staff from Title V programs and partners to form telehealth work group. - Develop and implement policies and procedures for telehealth in Title V programs. - Develop network of telehealth sites and personnel.

Workforce development: - Develop curriculum to train staff on the use of telehealth. - Implement training for staff. - Continuously evaluate training to make improvements to curriculum. - Implement long term follow-up of trainees to determine usefulness and use of training in their work.

Service Provision: - Identify services to be provided using telehealth. - Develop, implement, and evaluate pilot programs to implement telehealth for identified service. - Expand successful pilot programs

---

Education/Training: - Identify education and training to be provided using telehealth. - Develop, implement and evaluate pilot programs to implement telehealth for identified education and training. - Expand successful pilot programs.

SPM-1: The degree to which Title V programs utilize telehealth to improve access to services, education, and training for families and providers.

Introduction

Expanded use of telehealth technology was identified as a priority in the 2015 Title V 5-year needs assessment. The objective set was by July 2020, 100% of Title V programs use telehealth to provide services, education, and/or training. With the reduction in personnel resources, increases in travel costs, availability of the internet, HIPAA compliant software, and affordable devices, telehealth can be one of the tools to increase access to services, education, and training for families and providers while reducing costs and travel time especially for neighbor island and rural communities.

The National Survey of Children with Special Health Needs show that Hawaii children with special health care needs (CSHCN) have more difficulty accessing specialist care (5.9%) compared with non-CSHCN (1.1%). (Data source: NSCH 2016/17). The State of 2015 Hawaii Community Health Needs Assessment noted that fewer services are available in rural parts of Oahu and Neighbor Islands. Also, many specialized services are not available on each island, requiring costly air transportation to receive needed care. Use of telehealth in Hawaii for provision of genetics and behavioral health services have families and providers reporting high satisfaction with use of the technology and services provided.

There has been an increase in statewide efforts toward the use of telehealth by programs within the Department of Health (DOH), statewide hospitals, the University of Hawaii, state legislators, and our Congressional representation. These efforts are supported by the HRSA funded Pacific Basin Telehealth Resource Center based in the University of Hawaii that works to help stakeholders collaborate on telehealth activities.

Hawaii's Congressional Senator Brian Schatz and his aides continue to communicate with the State Telehealth Collaborative and support the use of telehealth in Hawaii. In 2014 the Legislature passed Act 159 for face-to-face and telehealth reimbursement parity. In July 2016, the legislature and Governor Ige enacted Act 226 which expanded the existing telehealth law that was passed in 2014. Act 226 requires the State's Medicaid managed care and fee-for-service programs to cover any service provided through telehealth that would be covered if the service were provided through in-person consultation between a patient and a healthcare provider. The law also requires payment parity which means that a service that can be provided by telehealth that is equivalent to a face-to-face service must be reimbursed at the same rate as the face-to-face service. Act 226 also made Hawaii one of the first states to remove geographic restrictions or requirements for telehealth coverage and restrictions on originating site requirements for telehealth coverage or reimbursement.

Within the DOH, the Director has made increasing the use of telehealth as one of the top priorities in the new strategic plan for the Department. To support telehealth activities, the Department was successful in obtaining funding from the 2018 state legislature to fund a position for a telehealth coordinator and some funding for pilot studies. Within the Family Health Services Division (FHSD) there is ongoing support for efforts to implement or increase telehealth activities for genetics, newborn screening, early intervention, and home visiting activities. As part of these efforts, workforce training about telehealth is being developed.

Other FHSD telehealth activities include the Office of Primary Care and Rural Health's support of Project ECHO Hawaii (echohawaii.org), a national innovative model that utilizes videoconferencing to build primary care workforce capacity while improving patient access to specialty health care in rural communities. Project ECHO was recognized by the state Medicaid program as a priority innovation initiative to build health workforce capacity and included as part of the Hawaii's 1115 waiver to the Centers for Medicare and Medicaid Services.

FHSD is also partnering with the DOH Developmental Disabilities Division to support a pilot teledentistry program at three early childhood locations in Kona on Hawaii Island. The project was expanded to Maui to serve early childhood programs (Head Start, Early Head Start, WIC, preschool) as well as a senior living facility.

There are 4 strategies for this measure: Infrastructure development, workforce development, service provision, and Education/Training. The strategies were developed by the FHSD staff, led by the CSHNB Genomics Section supervisor who serves as the FHSD lead for this priority.

FHSD funds telehealth activities through several federal grants from both HRSA and the Centers for Disease Control. Although Title V does not fund telehealth activities directly, key management and support staff funded by Title V facilitate the telehealth expansion activities described in this narrative.

Strategies to address this objective and NPM are discussed below.

Strategy 1: Telehealth infrastructure development

The Governor and the Director of Health continue to have telehealth as one of their top priorities for the state. The use of telehealth continued to increase including programs within the DOH, statewide hospitals, community organizations, and the University of Hawaii. These efforts are supported by the HRSA funded Pacific Basin Telehealth Resource Center based in the University of Hawaii that works to help stakeholders collaborate on telehealth activities.

Senator Brian Schatz and his aides continue to communicate with the DOH, University of Hawaii, and hospital representatives to discuss ways to increase the use of telehealth in Hawaii.

Third party payers and providers in the state are making progress on developing policies to implement Act 226 (2016) that removed the originating site restrictions, so telehealth can be done to a person’s home or work.

FHSD worked with the University of Hawaii to plan a statewide telehealth meeting which took place October 2017. State program staff, hospitals, healthcare providers attended the conference which covered current practices and policies and discussed needs for future support to expand telehealth in the state. FHSD staff presented about our telehealth activities and facilitated the break-out sessions to determine the needs of the community.

Strategy 2: Service Provision

Within FHSD, telehealth use is increasing for meetings, training, and education for staff and external partners. FHSD support continues its efforts to implement or increase telehealth clinical and service provision for genetics, newborn screening, early intervention, and home visiting activities. The Office of Primary Care and Rural Health continues to support Project ECHO Hawaii (echohawaii.org), which is an innovative model that utilizes videoconferencing to build primary care workforce capacity while improving patient access to specialty health care in rural communities. FHSD continues with the DOH Developmental Disabilities Division to support pilot teledentistry projects on the neighbor islands at early childhood and senior living settings. The Early Intervention Section continues its telehealth work group to plan, implement, and evaluate using telehealth to provide early intervention services to families and training to staff and providers.

The neighbor island FHSD staff use the videoconferencing equipment that was installed in 2017 to facilitate telehealth visits for their neighbor island families and participate in meetings and trainings. Genetics and neurology visits were completed using the technology. The FHSD staff are now working with neighbor island organizations, including the Native Hawaiian Health Center clinics, to plan and implement telehealth services at community sites outside the District Health Offices. Initial discussions seem to lead to a partnership between the Department of Health and the Veteran’s Administration to support a pilot program of telehealth kiosks in community locations such as libraries. This would eliminate the concern about wireless internet reception in the more remote areas on the neighbor islands since the kiosks would be hard wired to the internet.

Strategy 3: Workforce development

The telehealth training curriculum was implemented for FHSD staff. The training consists of nine on-line training modules and a one day in-person session. The HRSA funded Pacific Basin Telehealth Resource Center is worked with the Genomics Section to develop the in-person training to accompany the on-line telehealth training. The training course was stalled as we worked on developing new policies for coverage and reimbursement with the state third party payers. However, the Genetics program does provide short trainings for new users as needed so that they can use the telehealth systems for meetings and training. We will be resuming the training course in the summer of 2019.

Strategy 4: Education/Training

FHSD is also using videoconferencing on a daily basis for meetings and training. We have changed the vocabulary of the program staff and they routinely request to “Zoom” each other. We also have been able to schedule statewide training more easily since the trainings are now done using Zoom videoconferencing. The childhood lead prevention and maternal mortality programs have used the videoconferencing for their trainings.

State Performance Measure (SPM)

The FFY 2018 indicator for the SPM (The degree to which Title V programs utilize telehealth to improve access to

services and education for families and providers) is 12 out of 72. A copy of the completed data collection form can be found in the supporting documents. The Data Collection Form lists 24 strategy components organized by the three areas in telehealth activities:

- Infrastructure development
- Training/education development
- Service development

Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 72. Scoring is completed by FHSD staff. The data collection form is attached as a supporting document.

Factors Contributing to Success

The major factor contributing to success towards expanding telehealth in Title V programs continues to be support from the Governor, legislature, DOH administration, Division/Program leadership, program staff, and outside agencies such as the University of Hawaii and the HRSA funded Pacific Basin Telehealth Resource Center. The legislature approved funding during the 2017 legislative session for a State Telehealth Coordinator position with the DOH and development of a State Telehealth Plan. The DOH also consolidated the individual Zoom videoconferencing licenses into one HIPAA compliant corporate license to allow more efficient expansion for telehealth for our public health programs.

The prioritization of telehealth is pushing this Title V activity forward as a great example of what can be done in this area. The Title V activity also coincides with the telegenetics activities being developed and implemented as part of the HRSA funded Western States Regional Genetics Network which is administered within the Title V agency in Hawaii. This allows cross utilization of knowledge and resources.

Another factor contributing to supporting telehealth is the benefits for improving access for families and providers to services and education while containing costs. With more access to broadband internet and applications that work well on devices like smartphones, we can reach more families and providers more often without the cost and time for travel.

Challenges

The main challenge facing more rapid adoption of telehealth for the Title V programs is the limitation of staff time and competing priorities. As with other health departments, programs are experiencing staff retirements and departures with more difficulty filling positions with the many opportunities in the private sector. Since current staff continue to cover shortages, this can be a barrier to implement new opportunities in telehealth. However, the ability to reduce travel time and costs to attend meetings, trainings, and provide support and services to families makes it an attractive option for staff to make time to learn new skills.

Another key challenge is the families that would most benefit from telehealth are located in rural or neighbor island areas with limited wireless internet. While programs can bring the equipment and hotspots to provide the telehealth services to rural families telehealth resources may be hampered by poor or no reception.

Cross-Cutting/Systems Building - Application Year

SPM-1: The degree to which Title V programs utilize telehealth to improve access to services, education, and training for families and providers.

The objectives for SPM 1 were set based on anticipated completion of activities based on the work plan timetable. The Title V on-line telehealth training modules were implemented during FFY 2018 as part of the Title V training for staff and contracted providers. Unfortunately, the challenges to implementing services by telehealth has not allowed trained staff to actually implement sustainable telehealth services.

The Title V programs will continue to develop and implement plans and policies to use telehealth for services, education, and training. Technical assistance will be provided by current staff that have experience with telehealth activities and the Pacific Basin Telehealth Resource Center.

Other objectives include:

- By December 2019, increased Title V services and programs are being delivered by telehealth.
- By July 2020, a telehealth network for Title V activities is developed and in use.
- By July 2020, coverage for eligible services delivered by Title V programs via telehealth receive maximum reimbursement.

Title V Cross-Cutting/Systems Building Programs

Cross-cutting/Systems building programs administered by the Hawaii Title V program include:

Office of Primary Care and Rural Health: coordinates federal, state, and local efforts at improving the health of Hawaii's rural and medically underserved populations.

> **Primary Care Office**: administers primary care contracts to improve access to primary care for medically underserved populations through the Community Health Centers, including Federally Qualified Health Centers (FQHC) and recruitment and retention of health care providers.
>
> **Rural Health**: creates a focal point for rural health issues within each state, linking communities with state, federal and non-profit resources and helping to find long-term solutions. It keeps providers aware of new health care initiatives, collects and disseminate data and resources, and support workforce recruitment and retention. Contracts for rural hospitals provide essential access to inpatient, outpatient, and emergency medical services in rural communities

Oral Health: the state's dental public health program is responsible for data surveillance and assessment to support planning and coalition building.

Genetics Services: provides information and education about topics in genetics and services to neighbor island families.

Critical Access Hospitals (CAH): there are 24 hospitals in Hawaii and 9 are identified as Critical Access Hospitals which assists small rural hospitals to improve access to health services in rural communities: Hale Hoola Hamakua, Kahuku Hospital, Kau Hospital, Kauai Veterans Memorial Hospital, Kohala Hospital, Kula Hospital, Lanai Community Hospital, Molokai General Hospital, Samuel Mahelona Memorial Hospital. The program helps to support CAHs with improvements in operational, financial, and clinical functions. Medicare Rural Hospitality Flexibility Grant Program (FLEX) provides federal funding for the program.

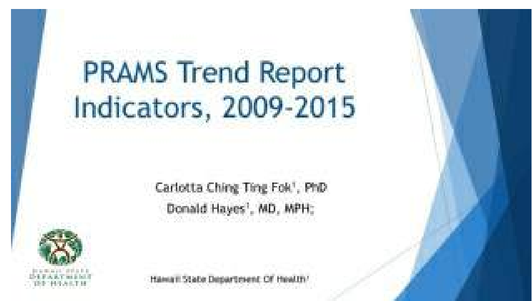
Hawaii, Maui, and Kauai District Health Offices: located on the less populated counties outside of Honolulu county which includes all of Oahu island. Within each DOH DHO there is an FHSD program managed by a Registered Nurse. The FHSD Nurse managers oversee personnel for WIC and CSHN including Early Intervention Services. Based on the organizational structure of the DHO and community needs, FHSD Nurse coordinators also manage a substantial range of other responsibilities including convening local death review teams, participating/convening numerous coalitions and advisory groups for FHSD and other DOH and DHS programs, and may also assist with monitoring for FHSD service contracts in their counties.

III.F. Public Input

Family Health Services Division (FHSD) involves communities, stakeholders, and program participants, including families, in policy and program decision-making at many levels. Integrating public input into the Title V MCH Block grant is critical to assure alignment with our partners to strengthen our collective impact. Consumer input also ensures Title V efforts are effective with the populations we serve. Input on Title V performance and strategy measures is collected continuously throughout the year. Since much of the Title V work is done in partnership, community collaboratives help determine strategies, assist with implementation, evaluation and revision of activities.

Because FHSD does not use Title V funds to fund local health departments or community-based providers, there are no stakeholders with a vested interest in Title V as a funding source. Most FHSD partners are aware of the importance of the Title V funding to support the FHSD programs and services provided to the community especially those who also receive HRSA/MCH Bureau funding. FHSD is continually challenged to improve on current efforts to engage stakeholders, including families and consumers, in the Title V work and the importance of MCH as a field in public health.

MCH assessment data, priorities, strategies, performance measure trends, and outcomes are regularly presented and reviewed by stakeholders and Title V implementing partners across the State.



FHSD engages and solicits input from community-based organizations, safety-net providers and consumers in both the 5-year needs assessment and ongoing work to develop strategies and implement the Title V 5-year plan.

Mechanisms through which input is solicited include: the Department of Health (DOH) website, surveys, community meetings, conferences, partner meetings, advisory groups, inter-agency committees, task forces, collaboratives, and focus groups.

Title V management, neighbor islands offices, and staff program leaders continue to reach out and solicit input from partners around the state for each of the identified priorities.

The Title V 2018 Report and 2020 Application was posted on the DOH website. A banner on DOH front page highlights the report availability.

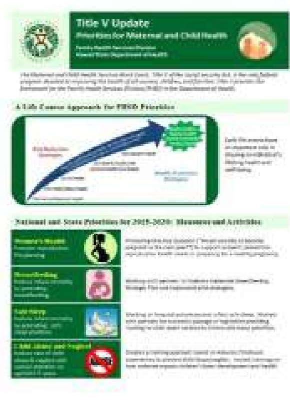
FHSD's website on Title V Maternal & Child Health Block Grant was updated to include the Title V Quick Fact Sheet and online survey http://health.hawaii.gov/fhsd/home/title-v-maternal-child-health-block-grant/ For ease of access, the Executive Summary is available through a separate link.

Following the submission of the Title V application to the federal MCH Bureau in July 2019, FHSD will post the final Title V application on the DOH website.

Users find the on-line access to the grant convenient and comments throughout the year can be submitted through a return email function on the website. While the site received 282 hits, no specific comments were received through the website.

Over the past year, many stakeholders have asked for information on the programs administered by Family Health Services Division (FHSD) with names of key program managers. In this year's Title V report the program charts and short descriptions have been included in the "Supporting Documents" that were developed in response to these requests.

In 2018, FHSD developed several informational products to educate community stakeholders on the Title V priorities and to collect public input. These publications are being updated for use in the needs assessment accompanying surveys to collect input on priorities and implementation strategies. The documents include:



- Title V Update on Priorities for Maternal and Child Health, with information on update of measures and activities for Hawaii Title V priorities and strategies, and information and data on the priorities.
- A summary of the Hawaii 5-year plan was shared with Title V staff, DOH partner agencies, national Title V meetings, and stakeholder meetings such as the Council for Developmental Disabilities and Hawaii Maternal Infant Health Collaborative. Updates to the plan will be made following submission of this year's report.

Staff frequently share information about their individual priorities at national conferences including the National Title X Directors Meeting, the ECCS Impact Grantee Meeting, the national Coalition Against Domestic Violence Conference, CityMatCH Leadership and MCH Epidemiology Conference, and the CDCs Rape Prevention and Education Grantee Leadership Meeting. Staff also promoted information at various statewide meetings and events including the Footsteps to Transition Fair, Special Parents Information Network (SPIN) Conference, the State Medicaid Providers Meeting, and State Early Childhood Action Strategies, and Hawaii Maternal Infant Health Collaborative.

Stakeholder input is generally favorable regarding the Title V priorities and supportive of the measures. Examples of

public feedback that changed elements of the Title V 5-year plan strategies follow.

- NPM-1: Women's Wellness Visits. The work for the priority is conducted in partnership with the Hawaii Maternal and Infant Health collaborative, comprised of over 120 participants including physicians, clinicians, public health professionals, community service providers, insurance representatives and health care administrators. Input from HMIHC Pre-/Inter-conception Workgroup members shape the strategies, activities and measures for NPM-1. New strategy measures will be developed for next year's report and will align with HMIHC evaluation projects currently underway. Plans for the Title V narrative are updated at the annual HMIHC meeting based on updates/progress achieved.

- NPM-4: Breastfeeding. The State Breastfeeding Strategic Planning Workgroup, a subcommittee of the HMIHC, provided comments on the use of data measures such as 'ever breastfed' and 'exclusively breastfed through 6 months' and cautioned messaging should support all mothers and families who are breastfeeding for whatever the duration. The group also discussed whether to utilize infant mortality data or focus on primarily on promoting breastfeeding. The concerns were documented to use for implementation of the strategic plan and to develop breastfeeding messaging.

- NPM-5: Safe Sleep. Title V partnered with the state Child Care Licensing Program at the Department of Human Services (DHS) to develop a Safe Sleep Guide for Parents and one for Caregivers. Families from the DHS First-To-Work (FTW) program were surveyed statewide to collect input on the messaging and the document's graphic design. As part of the survey implementation Title V staff conducted an in-service on Safe Sleep for the FTW workers statewide who were administering the survey with families. FTW requested the training since many staff reported a lack of knowledge about the issue. Most families reported general awareness about safe sleep practices; however, several topics were identified as new including:
    - Leaving stuffed animals or toys in the crib;
    - Leaving a sleeping baby in a swing;
    - Leaving a sleeping baby in a car seat;
    - Allowing a baby to sleep on the couch or an air mattress; and
    - Allowing smoking in the home.

  Families also provided specific feedback on design elements of the poster and guide. The guides are used by the Child Care program to implement a new policy mandate for training of all licensed child care providers on safe sleep. Guides were also distributed by other programs such as WIC.

- NPM-6: Developmental Screening. Providers at the Maui Early Childhood conference requested more informational resources on developmental screening for children who may not be eligible for Early Intervention services. The conference attendees commented that conducting the screening is a relatively easy performance measure to achieve. The real challenge is ensuring timely access to services or supports once issues are identified. Thus, the workgroup decided to put more emphasis on the actual community services and supports which is reflected in one of the strategies and strategy measures (ESM): development of a data system to track the number of children screened, number of children referred, and number of children receiving services.

- SPM-4: Child Abuse and Neglect. CAN prevention has three primary mechanisms for community input including:
    - the Hawaii Children's Trust Fund (HCTF) Advisory Committee (eleven private and public members),
    - the HCTF Coalition with 30 active members representing key community partners working to prevent child maltreatment across the islands, and
    - the Prevent Child Abuse Hawaii, Child Abuse Prevention Planning Council comprised of 15 active members representing the military and community-based private agencies.

  All of these groups serve a range of consumers and participate in their respective membership to be a voice for their communities. Comments from these groups refocused FHSD efforts on building a surveillance system to identify data sources and develop means for data sharing. In Fall 2018 the CAN prevention program also conducted statewide focus groups to documents needs among the special needs/developmentally disabled population. The focus groups included providers as well as families. Data collected from the meetings is being analyzed and will be published as part of the Title V needs assessment.

- NPM-10: Adolescent Health. In 2018, the Adolescent Health Unit (AHU) needed to revise its strategy for adolescent wellness visits (AWV) by working with medical providers to improve the quality of the AWV because a key project partner was lost. The AHU collected input from youth service providers and community health center staff (as part of contract monitoring visits) to redirect its strategy to partner with community health workers, youth services providers, and teens themselves to promote AWV and link adolescents to preventive healthcare services. The AHU developed an Adolescent Resource Toolkit (ART) which was tested with over 200 adolescents at State Personal Responsibility Education Program (PREP) service sites. Input from adolescents is being used to assure a teen-centered focus for the ART health information.

Preparing for My Adult Health Care

Name: Birthdate: Age:

- Completed by Youth/Young Adult
- Completed by Parent/Caregiver, if youth/young adult is unable to do so
  - * Point of view: Parent or Child (circle)

Instruction: For each statement below, check the best answer. Date:

MY HEALTH	Yes	I am learning	I want help to learn	Does not apply
I live healthy (brushing/flossing teeth, healthy foods, exercise, sleep)				
I know the name of my health conditions and how they affect me				
I know how to get help when I'm not feeling well				
MY DOCTORS and PROVIDERS	**Yes**	**I am learning**	**I want help to learn**	**Does not apply**
I can schedule visits with my doctor and dentist regularly for check-ups				
I talk with my doctor/provider about my concerns				
I know my doctor's names and contact information				
I plan my rides to my appointments				
MY MEDICATIONS	**Yes**	**I am learning**	**I want help to learn**	**Does not apply**
I know my medicines (what they are, how much to take, and when to take them)				
I know how to get more refills of my medicines				
I know the name and location of my pharmacy *Name of pharmacy:				
MY MEDICAL SUPPLIES	**Yes**	**I am learning**	**I want help to learn**	**Does not apply**
I know how to order my supplies, formula, batteries, etc.				
I know who to call when my equipment does not work, or when it needs to be replaced				
I know how to file my records and receipts				
MY HEALTH INSURANCE	**Yes**	**I am learning**	**I want help to learn**	**Does not apply**
I carry my insurance card in my wallet				
I understand my medical insurance and how to use it				
I know how to get insurance when I turn 18-years-old, 19-years-old and 26-years-old				
MY ADULT HEALTH CARE	**Yes**	**I am learning**	**I want help to learn**	**Does not apply**
At 18-years-old, I know I have the right to see the doctor alone or choose to have my support people with me				
I help in making medical decisions				
I keep my own health record up-to-date				
I know who my adult health providers will be				

Transition Readiness Assessment Checklist (TRAC)

- NPM-12: Transition to Adult Care. Substantial input was obtained from youth, families, as well as the pediatric and professional community to develop key transition informational materials: The Transition Readiness Assessment Checklist (TRAC) and the My Path to Adult Health Care (PATH) handout. Input helped reduced the complexity of the materials, improved ease of understanding, and the visual design. Also, a point system was added to the TRAC to assist users quantify and qualify their transition progress.
- NPM-13.2: Oral Health for Children. The DOH Oral Health program launched a year long process to develop a state oral health state plan. Input has been collected through the state oral health coalition, an online survey, website, and community town hall meetings held on all the islands, culminating in a statewide conference in May 2018. The daft community plan is currently circulating for final comment and will be finalized later this year. Information will be used for the Title V website. Title V is also working with key community stakeholders to formulate recommendations for its draft Head Start/Early Head Start Oral Health screening survey.

Examples of feedback/comments that were obtained at in-person:

- As part of Hawaii's review of its child health priorities under the latest Title V guidance, there was strong sentiment that CAN prevention must be retained as a state priority. Thus, SPM-4 was created in last year's report. Stakeholders expressed a need for improved data collection and dissemination to help guide statewide planning and policy which was included as one of the strategies.
- Community advocates also expressed a need to retain oral health as a state priority issue despite the loss of DOH funding for the state program. The NPM-13.2 was retained and Title V continues to support ongoing surveillance, community coalition building, and state planning efforts.
- The federal Family First legislation directs state Child Welfare Services (CWS) programs to integrate evidence-based prevention services, stakeholders and agency partners requested increased collaboration/coordination between DOH CAN prevention programs and DHS CWS programs. In FY 2019 there was increased coordination between the two Departments and its work with community partners to improve service delivery and prevention efforts. FHSD assisted with an assessment of existing evidence-based program models in Hawaii.
- Several comments from both external and internal stakeholders requested greater attention on more coordinated DOH efforts to address the needs of special populations including:
  - homeless families,
  - Pacific Island migrants under the Compacts of Free Association,
  - immigrant families (description of the population in Hawaii, issues and needs, impact of federal policy changes), and
  - Native Hawaiian health.

FHSD formed a needs assessment collaborative to utilize resources from Title V, MIECHV, CAN Prevention, the Primary Care Office, and state Early Childhood/Preschool Development Grant to jointly assess needs of these four special populations.

Needs Assessment: Community Input

As part of its ongoing needs assessment process, in FY 2019 the Title V program piloted several types of surveys at community meetings and events with nearly 300 responses. The different surveys were designed to gather general feedback on the key concerns of families with special needs children, as well as specific feedback on the Title V priorities, and emerging issues.

III.G. Technical Assistance

With the loss of the University of Hawaii Office of Public Health Studies Maternal Child Health certificate program, Hawaii has continued to explore technical assistance (TA) opportunities with the University's public health faculty. In 2018, Hawaii Title V used SSDI funds to secure planning and data analysis TA with Jeanelle Sugimoto-Matsuda, Ph.D., public health research faculty with the University's School of Medicine (as described in the Needs Assessment update). Recently, Dr. Sugimoto-Matsuda accepted a faculty position at the University of Hawaii Office of Public Health Studies (OPHS). Her TA has been instrumental in building staff public health knowledge and practice. Title V is also working in collaboration with the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) needs assessment consultant, Elizabeth McFarlane, Ph.D., Associate Professor at OPHS.

The Title V agency continues to partner with the MCH Leadership Education in Neurodevelopmental Disabilities (LEND) program to provide program support for the Title V Leadership team that includes program staff serving as lead for the national and state priority issues. In addition, LEND routinely recruits participants for their training cohorts from Title V staff including those on the neighbor islands.

Hawaii has also relied on national TA becomes to develop leadership and core public health skills and competencies. TA and support provided by the Maternal Child Health (MCH) Bureau and Association of Maternal, Child Health Programs (AMCHP) and the Georgetown University Evidence Center have been helpful including learning labs, consultation with program officers and subject matter experts, Region IX conference calls, national partnership conferences, and networking with other state Title V coordinators.

Hawaii has a cohort participating in the Spring 2019 MCH Workforce Development Center Skills Building Institute with a focus to promote transition planning to adult health care for all adolescents including those with special health care needs.

At this time Hawaii has no plans to submit a TA request.

IV. Title V-Medicaid IAA/MOU

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

V. Supporting Documents

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

Supporting Document #01 - Map of Birthing Hospitals.pdf

Supporting Document #02 - FHSD Program Descriptions.pdf

Supporting Document #03 - Logic models.pdf

Supporting Document #04 - Needs Assessment Data Summary.pdf

Supporting Document #05 - GLOSSARY OF TERMS.pdf

VI. Organizational Chart

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

VII. Appendix

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: Hawaii

	FY 20 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,077,106	
A. Preventive and Primary Care for Children	$ 626,263	(30.1%)
B. Children with Special Health Care Needs	$ 816,576	(39.3%)
C. Title V Administrative Costs	$ 72,424	(3.5%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,515,263	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 31,499,929	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 203,441	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 13,584,510	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 45,287,880	
A. Your State's FY 1989 Maintenance of Effort Amount $ 11,910,549		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 47,364,986	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 45,765,848	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 93,130,834	

OTHER FEDERAL FUNDS	FY 20 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Program (CBCAP)	$ 415,271
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 29,930,606
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Genetic Services Project	$ 600,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS)	$ 426,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	$ 165,389
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 236,913
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 157,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 370,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 297,297
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 400,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Zika Surveillance Systems Grant Program	$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 7,388,195

OTHER FEDERAL FUNDS	FY 20 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Health	$ 179,270
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,000,000
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 2,301,533
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Medicare Rural Hospital Flexibility Program	$ 446,074
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospital Improvement Program	$ 101,700

	FY 18 Annual Report Budgeted		FY 18 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,989,226		$ 1,882,488	
A. Preventive and Primary Care for Children	$ 701,684	(35.3%)	$ 566,371	(30%)
B. Children with Special Health Care Needs	$ 713,393	(35.9%)	$ 779,064	(41.3%)
C. Title V Administrative Costs	$ 190,447	(9.6%)	$ 58,590	(3.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,605,524		$ 1,404,025	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 28,414,686		$ 27,324,746	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 63,078		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 16,422,876		$ 11,056,301	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 44,900,640		$ 38,381,047	
A. Your State's FY 1989 Maintenance of Effort Amount $ 11,910,549				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 46,889,866		$ 40,263,535	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 49,970,074		$ 39,143,194	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 96,859,940		$ 79,406,729	

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Program (CBCAP)	$ 454,196	$ 238,392
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 28,461,369	$ 26,507,018
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Genetic Services Project	$ 600,000	$ 699,048
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS)	$ 426,000	$ 455,210
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 157,000	$ 143,035
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 255,086	$ 322,909
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 40,000	$ 108,820
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 250,000	$ 502,763
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 191,116	$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 575,300	$ 102,027
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 2,247,675	$ 2,136,282
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 12,969,228	$ 4,781,918
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 143,825	$ 234,670

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 192,669	$ 240,257
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,157,300	$ 1,530,525
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Health	$ 172,000	$ 186,547
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	$ 167,994	$ 200,244
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Medicare Rural Hospitality Flexibility Program	$ 419,316	$ 417,490
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospital Improvement Program	$ 90,000	$ 164,451
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Hawaii Birth Defects Surveillance, Intervention, and Follow-up for Zika Virus		$ 86,329
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Hawaii Childhood Lead Poisoning Prevention Program		$ 85,259

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Based on SFY 2018 award plus $100K for Epidemiologist payroll cost which is in alignment with fiscal's new methodology.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: The amount budgeted for this category in the fiscal year 2019 application was $728,721, and the amount budgeted for this category in the fiscal year 2020 application is $626,263. The decrease of $102,458 is primarily due to FHSD budgeting substantially lower for the CDC assigned Epidemiologist and the FHSD Physician vacated positions in FY20.	
3.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: The category “Other Funds” increased 100% from $0 in the fiscal year 2019 application to $203,441 in the fiscal year 2020 application. In years past, the practice was to include these funds in the “Program Income” category but technically, the funds represent an annual interdepartmental funds transfer from the Department of Human Services and will be reported as “Other Funds” from the FY 2020 budget moving forward.	
4.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: The amount budgeted in this category for fiscal year 2018 was $701,684, however the amount actually expended was $566,371, a difference of $135,313. This variance is primarily due to salary and fringe benefit savings from Title V funded vacancies.	
5.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2018**

	Column Name:	**Annual Report Expended**

Field Note:
DOH/FHSD budget allocation methodology changed from last year therefore budget allotted for Title V Admin. Costs was greater than actual FY18 expenditures. New methodology will align from next fiscal year.

6.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**

Field Note:
The budgeted amount for the category “Other Funds” was only $63,078 in fiscal year 2018 but there were no actual expenditures.

7.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**

Field Note:
The budgeted number matches the state approved "ceiling" for special funds which is the legal spending limit for program income whereas the true expenditures will generally always be substantially lower than the legal spending limit. These funds do not lapse, they carry forward from year to year.

Data Alerts: None

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

State: Hawaii

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	$ 251,553	$ 208,529
2. Infants < 1 year	$ 251,553	$ 208,529
3. Children 1 through 21 Years	$ 626,263	$ 566,371
4. CSHCN	$ 816,576	$ 779,064
5. All Others	$ 58,737	$ 61,405
Federal Total of Individuals Served	$ 2,004,682	$ 1,823,898

IB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	$ 5,262,244	$ 3,595,513
2. Infants < 1 year	$ 3,647,958	$ 2,723,102
3. Children 1 through 21 Years	$ 7,445,843	$ 8,022,326
4. CSHCN	$ 23,183,370	$ 19,741,714
5. All Others	$ 5,748,465	$ 4,298,392
Non-Federal Total of Individuals Served	$ 45,287,880	$ 38,381,047
Federal State MCH Block Grant Partnership Total	$ 47,292,562	$ 40,204,945

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Hawaii

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 147,106	$ 139,017
3. Public Health Services and Systems	$ 1,930,000	$ 1,743,471
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 2,077,106	$ 1,882,488

IIB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	$ 24,469,591	$ 18,404,224
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,661,475	$ 2,572,494
B. Preventive and Primary Care Services for Children	$ 9,241,910	$ 4,977,358
C. Services for CSHCN	$ 13,566,206	$ 10,854,372
2. Enabling Services	$ 11,527,086	$ 10,886,698
3. Public Health Services and Systems	$ 9,291,203	$ 9,090,125
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 1,477,020
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 1,271,195
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Primary and Urgent Care in Hana		$ 1,130,000
Waianae Coast Emergency Room Services		$ 1,794,230
Early Intervention Services (POS)		$ 12,731,779
Direct Services Line 4 Expended Total		$ 18,404,224
Non-Federal Total	$ 45,287,880	$ 38,381,047

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	Field Name:	IIA. Federal MCH Block Grant, 3. Public Health Services and Systems
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**

Field Note:
The Federal MCH Block Grant budget for Public Health Services and Systems was $2,260,948 in FY19. The FY20 budget for this category decreased by $330,948 to $1,930,000. The decrease in FY20 is due to a change in methodology for calculating this category. The methodology for budgeting this category will remain consistent moving forward.

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

State: Hawaii

Total Births by Occurrence: 17,022 **Data Source Year: 2018**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	16,915 (99.4%)	1,111	47	47 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methylglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency
Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy	

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Children are monitored for at least a year or longer (up to 21 years old) if needed. Length of time depends on medical condition, health status of child, and social or other issues. This is done by the NBMS staff; CSHNB nurses, nutritionist, or social workers, or public health nurses.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

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

State: Hawaii

Annual Report Year 2018

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

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,013	66.0	0.0	14.0	18.0	2.0
2. Infants < 1 Year of Age	821	32.0	0.0	65.0	3.0	0.0
3. Children 1 through 21 Years of Age	12,046	30.0	0.0	67.0	3.0	0.0
3a. Children with Special Health Care Needs	7,254	27.0	0.0	70.0	3.0	0.0
4. Others	19,079	13.0	0.0	83.0	4.0	0.0
Total	32,959					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	17,517	No	17,022	46	7,830	1,013
2. Infants < 1 Year of Age	17,519	No	17,022	100	17,022	821
3. Children 1 through 21 Years of Age	352,787	Yes	352,787	12	42,334	12,046
3a. Children with Special Health Care Needs	48,896	Yes	48,896	17	8,312	7,254
4. Others	1,056,801	Yes	1,056,801	3	31,704	19,079

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2018**
	Field Note: Programs that contributed to this count include pregnant women who received Perinatal Support Services (PSS; 1,013). Note that the decline in number from last year (2017: 1287) is in part due to the shortened PSS contract year for our 7 providers (up until 12/27/18); the family planning activities focused on unintentional pregnancies; the popularity of long-acting reversible contraception (LARC) among women and teens; and the decisions by young couples to delay pregnancies to attain more education or to advance their careers.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2018**
	Field Note: Programs that contributed to this count of infants < 1 year of age include 2018 Primary Care Contracts (766), which are state funded for safely net providers including Federally Qualified Health Centers to provide services for the uninsured/underinsured. Additionally, there was no way to differentiate the primary source of coverage for those that were provided services through the underinsured due to lack of access to the data. Other programs that contributed to this count include Family Strengthening Program [home reach (32)],Maui District Health Office (17), and Kauai District Health Office (6). Note. The percentages of primary source of coverage are based on 2017 American Community Survey for Children 1-21.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2018**
	Field Note: Programs that contributed to this count include 2018 Primary Care Contracts (3,226), which are state funded for safely net providers including Federally Qualified Health Centers to provide services for the uninsured/underinsured. Other programs that contributed to this count include Family Planning Services (40% State Contribution; 1,234), Maui District Health Office (44), Family Strengthening Programs [Community Based Parenting Education (130), Home Reach (158)], and Children with Special Health Care Needs in 3a (7,254). Note that Children the count for Community Based Parenting Education (130) includes infants < 1 year as there was no way to separate the count between the two groups. The decline in service numbers from previous year reflects the end of the Children Exposed to Violence service contract. Note. The percentages of primary source of coverage are based on 2017 American Community Survey for Children 1-21.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2018**

Field Note:
2018 data for the number of children serviced contributed by CSHNP (7,254). Programs that contributed to the direct and enabling count of children with special health care needs include Children with Special Health Needs Section (631); genetics, metabolic, hemoglobinopathy, Neighbor Island genetics, telemedicine clinics (1,225); Newborn Metabolic Screening Program follow-up (1,111); Newborn Hearing Screening Program follow-up (345); Early Intervention Section (3,513); Hiʻilei Developmental Screening Program (29); Hawaii Childhood Lead Poisoning Prevention follow-up (400). The distribution of source of coverage is based on National Survey of Children's Health – CSHCN, 2016-2017

5.	**Field Name:**	**Others**
	Fiscal Year:	**2018**

Field Note:
Programs that contributed to this count of others include 2018 Primary Care Contracts (14,395), which are state funded for safely net providers including Federally Qualified Health Centers to provide services for the uninsured/underinsured. Additionally, there was no way to differentiate the primary source of coverage for those that were provided services through the underinsured due to lack of access to the data. The count also included Family Planning Services (40% State Contribution; 3,160), Family Strengthening Programs [Community Based Parenting Education (172), Home Reach (25), Parent Line (Number of calls received on the State MCH Hotline; 1,283) and Kauai District Health Office (44) .
Note. The decline in service numbers from previous year reflects the end of the Children Exposed to Violence service contract. The percentages of primary source of coverage are based on 2017 American Community Survey for adults 22+.

6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2018**

Field Note:
The decline in service numbers from previous year reflects the end of the Children Exposed to Violence service contract.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2018**

Field Note:
Numerator : Programs that contributed to the numerator (7,883) included pregnant women who received Perinatal Support Services (1,013), the use of WIC Program during pregnancy estimated by 2015 PRAMS data (6,775; 39.8% of 2018 resident births), and Home Visiting Program (95).
Denominator: Number of 2018 resident births=17,022

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2018**

Field Note:
Estimated by percentage of newborn metabolic screening (99.4%)

3.	**Field Name:**	**Children 1 Through 21 Years of Age**

	Fiscal Year:	**2018**

Field Note:
Numerator: Programs contributed to the numerator (41,243) included Primary Care Contracts (3,226), Maui District Health Office (44), Family Planning Services (both federal and state contribution;3,085), Home Visiting (533), Family Strengthening Programs [Community Based Parenting Education (130), Parent Line (824), Home Reach (158)], Sexual Violence Prevention Program (6,010), Participation in WIC Program (aged 1-5; state provided administrative support, 19,355), Adolescent Health (624), and Children with Special Health Care Needs (7,254)
Denominator: 2017 Census Estimate (352,787)

4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2018**

Field Note:
3a: Programs that contributed to the direct and enabling count of children with special health care needs include Children with Special Health Needs Section (631); genetics, metabolic, hemoglobinopathy, Neighbor Island genetics, telemedicine clinics (1,225); Newborn Metabolic Screening Program follow-up (1,111); Newborn Hearing Screening Program follow-up (345); Early Intervention Section (3,513); Hiʻilei Developmental Screening Program (29); Hawaii Childhood Lead Poisoning Prevention follow-up (400). An estimated 2% of the CYSHCN population was reached through various community events with CSHNB educational outreach for developmental screening, childhood lead poisoning prevention, early intervention services, and transition to adult health care.
The denominator was based on National Survey of Children's Health CSHCN Prevalence Estimates 1-17 (2016-2017) multiplied by US Census Bureau Population Estimates 1-21 (48,896).

5.	**Field Name:**	**Others**
	Fiscal Year:	**2018**

Field Note:
Numerator: Programs contributed to the numerator (29,519) included Primary Care Contracts (14,395), Kauai District Health Office (44), Family Planning Services (federal and state contribution; 7,901), Family Strengthening Programs [Community Based Parenting Education (172), Parent Line (Number of calls received on the State MCH Hotline;1,283), Home Reach (25)], Sexual Violence Prevention Program (1,901), Adolescent Health (431), and WIC services for postpartum women (3,367).
Denominator: 2017 Census Estimate (1,056,801)
Note. The decline in percentage served from previous year reflects the end of the Children Exposed to Violence service contract.

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Hawaii

Annual Report Year 2018

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	16,727	4,147	394	2,563	10	4,264	1,654	3,456	239
Title V Served	16,627	4,122	392	2,548	10	4,238	1,644	3,435	238
Eligible for Title XIX	6,594	827	118	0	147	2,168	1,574	0	1,760
2. Total Infants in State	17,950	2,661	278	3,042	32	3,865	2,266	5,806	0
Title V Served	17,842	2,645	276	3,024	32	3,842	2,252	5,771	0
Eligible for Title XIX	8,903	103	28	0	29	370	136	0	8,237

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Information obtained from maternal race as reported in 2018 vital statistics birth certificate data. The number of more than single birth (twin, triplet) is subtracted from the number of births.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Used overall estimate of newborn metabolic screening percentage (99.4%) in 2018 applied to overall total and each race group.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Data Sauce: Data from Hawaii Medicaid program in 2018 and reflects unduplicated clients served Note: Data on ethnicity was not provided by the Hawaii Medicaid Program. The race groups might include both Hispanic and non-Hispanic origin. Note: Collection of race differs between that reported for Title V served and those reported for Title XIX so are not directly comparable. For example, the number of clients of more than one race was not provided by the Hawaii Medicaid Program.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Total number of infants based on 2017 CDC, NCHS, Bridged-Race population estimates from https://wonder.cdc.gov. 2018 information is not available yet. The Bridged-Race population groups reported are different from that requested in Title V. To determine race specific estimates for Title V, the distribution of race based on children under 5 years based on 2010 Census was applied to total infants in state as more current data was not available for requested race groups. Additionally, American Community Survey does not report out single year age estimates. Note: Collection of race varies from that reported from vital statistics so not directly comparable. For example, more than one race reported was not available from data requested.	

5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2018**
	Column Name:	**Total**

Field Note:
Based on the proportion of infants receiving newborn metabolic screening (99.4% in 2018)

6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2018**
	Column Name:	**Total**

Field Note:
Data source: Data from Hawaii Medicaid program from 2018 data and reflects unduplicated clients served

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Hawaii

A. State MCH Toll-Free Telephone Lines	2020 Application Year	2018 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 816-1222	(800) 816-1222
2. State MCH Toll-Free "Hotline" Name	The Parent Line	The Parent Line
3. Name of Contact Person for State MCH "Hotline"	Eydie McNicoll	Eydie McNicoll
4. Contact Person's Telephone Number	(808) 681-1520	(808) 681-1520
5. Number of Calls Received on the State MCH "Hotline"		1,283

B. Other Appropriate Methods	2020 Application Year	2018 Annual Report Year
1. Other Toll-Free "Hotline" Names	Early Intervention Referral Line	Early Intervention Referral Line
2. Number of Calls on Other Toll-Free "Hotlines"		3,433
3. State Title V Program Website Address	http://health.hawaii.gov/fhsd	http://health.hawaii.gov/fhsd
4. Number of Hits to the State Title V Program Website		1,538
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Hawaii

1. Title V Maternal and Child Health (MCH) Director	
Name	Matthew J. Shim, Ph.D., M.P.H.
Title	Chief, Family Health Services Division
Address 1	1250 Punchbowl Street, Room 216
Address 2	
City/State/Zip	Honolulu / HI / 96813
Telephone	(808) 586-4122
Extension	
Email	matthew.shim@doh.hawaii.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Patricia Heu, M.D
Title	Chief, Children with Special Health Needs Branch
Address 1	741 Sunset Avenue
Address 2	CSHNP
City/State/Zip	Honolulu / HI / 96816
Telephone	(808) 733-9070
Extension	
Email	patricia.heu@doh.hawaii.gov

3. State Family or Youth Leader (Optional)	
Name	Leolinda Parlin
Title	Director, Hilopaa Family to Family Information
Address 1	1319 Punahou St. Ste 739
Address 2	
City/State/Zip	Honolulu / HI / 96826
Telephone	(808) 791-3467
Extension	
Email	leo@hilopaa.org

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Hawaii

Application Year 2020

No.	Priority Need
1.	Promote reproductive life planning
2.	Reduce the rate of infant mortality
3.	Improve the percentage of children screened early and continuously age 0-5 years for developmental delay
4.	Reduce the rate of child abuse and neglect with special attention on ages 0-5 years.
5.	Improve the percentage of youth with special health care needs ages 12-21 years who receive services necessary to make transitions to adult health care.
6.	Improve the oral health of children
7.	Improve the healthy development, health, safety, and well-being of adolescents
8.	Improve access to services through telehealth

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Promote reproductive life planning	Continued	
2.	Reduce the rate of infant mortality	New	
3.	Improve the percentage of children screened early and continuously age 0-5 years for developmental delay	Continued	
4.	Reduce the rate of child abuse and neglect with special attention on ages 0-5 years.	Continued	
5.	Improve the percentage of youth with special health care needs ages 14-21 years who receive services necessary to make transitions to adult health care.	Continued	
6.	Improve the oral health of children and pregnant women.	Continued	
7.	Improve the healthy development, health, safety, and well-being of adolescents	New	
8.	Improve access to services through telehealth	New	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Hawaii

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	76.5 %	0.3 %	12,515	16,355
2016	75.9 %	0.3 %	13,232	17,426
2015	77.2 %	0.3 %	13,650	17,680
2014	77.9 %	0.3 %	13,696	17,578

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	126.6	10.6	144	11,376
2014	135.7	9.5	205	15,112
2013	101.2	8.1	157	15,516
2012	106.8	8.3	167	15,632
2011	77.7	7.1	121	15,567
2010	44.9	5.4	70	15,585
2009	54.4	5.9	86	15,817
2008	49.9	5.6	81	16,225

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	13.4
Numerator	12
Denominator	89,650
Data Source	Vital Statistics
Data Source Year	2014-2018

NOM 3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	8.5 %	0.2 %	1,491	17,508
2016	8.5 %	0.2 %	1,537	18,045
2015	8.3 %	0.2 %	1,531	18,392
2014	7.9 %	0.2 %	1,462	18,526
2013	8.2 %	0.2 %	1,562	18,970
2012	8.1 %	0.2 %	1,542	18,975
2011	8.2 %	0.2 %	1,557	18,947
2010	8.3 %	0.2 %	1,584	18,972
2009	8.4 %	0.2 %	1,592	18,872

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	10.4 %	0.2 %	1,829	17,508
2016	10.5 %	0.2 %	1,904	18,053
2015	10.1 %	0.2 %	1,861	18,409
2014	10.0 %	0.2 %	1,862	18,537
2013	10.2 %	0.2 %	1,928	18,959
2012	9.9 %	0.2 %	1,885	18,964
2011	9.9 %	0.2 %	1,880	18,938
2010	10.5 %	0.2 %	1,985	18,953
2009	11.1 %	0.2 %	2,094	18,785

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	28.2 %	0.3 %	4,940	17,508
2016	27.8 %	0.3 %	5,022	18,053
2015	27.9 %	0.3 %	5,140	18,409
2014	27.6 %	0.3 %	5,115	18,537
2013	26.5 %	0.3 %	5,024	18,959
2012	26.4 %	0.3 %	5,012	18,964
2011	27.0 %	0.3 %	5,104	18,938
2010	26.9 %	0.3 %	5,089	18,953
2009	28.4 %	0.3 %	5,326	18,785

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	6.0 %			
2013/Q2-2014/Q1	7.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	5.6	0.6	102	18,106
2015	4.9	0.5	90	18,452
2014	5.0	0.5	93	18,591
2013	6.7	0.6	128	19,038
2012	5.4	0.5	103	19,028
2011	6.0	0.6	115	19,012
2010	6.1	0.6	116	19,032
2009	6.0	0.6	114	18,935

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	6.0	0.6	109	18,059
2015	5.7	0.6	105	18,420
2014	4.5	0.5	83	18,550
2013	6.4	0.6	121	18,987
2012	4.8	0.5	92	18,980
2011	5.3	0.5	100	18,956
2010	6.2	0.6	118	18,988
2009	5.9	0.6	112	18,887

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	3.8	0.5	68	18,059
2015	3.6	0.5	67	18,420
2014	3.3	0.4	62	18,550
2013	4.6	0.5	87	18,987
2012	3.6	0.4	68	18,980
2011	3.6	0.4	68	18,956
2010	4.0	0.5	76	18,988
2009	4.4	0.5	83	18,887

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	2.3	0.4	41	18,059
2015	2.1	0.3	38	18,420
2014	1.1	0.3	21	18,550
2013	1.8	0.3	34	18,987
2012	1.3	0.3	24	18,980
2011	1.7	0.3	32	18,956
2010	2.2	0.3	42	18,988
2009	1.5	0.3	29	18,887

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	216.0	34.6	39	18,059
2015	228.0	35.2	42	18,420
2014	177.9	31.0	33	18,550
2013	258.1	36.9	49	18,987
2012	200.2	32.5	38	18,980
2011	200.5	32.6	38	18,956
2010	221.2	34.2	42	18,988
2009	233.0	35.2	44	18,887

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	94.1 ⚡	22.8 ⚡	17 ⚡	18,059 ⚡
2015	76.0 ⚡	20.3 ⚡	14 ⚡	18,420 ⚡
2014	NR 🏴	NR 🏴	NR 🏴	NR 🏴
2013	79.0 ⚡	20.4 ⚡	15 ⚡	18,987 ⚡
2012	63.2 ⚡	18.3 ⚡	12 ⚡	18,980 ⚡
2011	NR 🏴	NR 🏴	NR 🏴	NR 🏴
2010	115.9	24.7	22	18,988
2009	NR 🏴	NR 🏴	NR 🏴	NR 🏴

Legends:

🏴 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	8.7 %	1.0 %	1,522	17,555
2014	8.5 %	1.0 %	1,474	17,402
2013	7.6 %	0.9 %	1,368	18,029
2012	7.9 %	0.9 %	1,416	17,864
2011	6.9 %	0.8 %	1,267	18,437
2010	7.2 %	0.8 %	1,328	18,461
2009	6.7 %	0.8 %	1,230	18,374
2008	6.3 %	0.6 %	1,167	18,459
2007	6.0 %	0.6 %	1,107	18,342

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	1.1 ϟ	0.3 ϟ	16 ϟ	15,111 ϟ
2015	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2014	1.4	0.3	22	15,358
2013	0.8 ϟ	0.2 ϟ	12 ϟ	15,722 ϟ
2012	0.8 ϟ	0.2 ϟ	13 ϟ	15,869 ϟ
2011	0.8 ϟ	0.2 ϟ	13 ϟ	15,757 ϟ
2010	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2009	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2008	0.8 ϟ	0.2 ϟ	13 ϟ	16,419 ϟ

Legends:

⚑ Indicator has a numerator ≤10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

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

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

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

NOM 13 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	9.5 %	1.1 %	27,331	287,697
2016	10.9 %	1.4 %	32,106	295,883

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	18.2	3.4	29	158,951
2016	16.8	3.2	27	160,245
2015	14.4	3.0	23	160,241
2014	14.5	3.0	23	158,910
2013	20.2	3.6	32	158,268
2012	10.9 ϟ	2.7 ϟ	17 ϟ	155,558 ϟ
2011	16.8	3.3	26	154,442
2010	14.4	3.1	22	153,004
2009	19.3	3.6	29	150,364

Legends:

⚑ Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	25.8	4.0	41	159,029
2016	33.7	4.6	54	160,416
2015	27.0	4.1	44	163,073
2014	20.9	3.6	34	162,896
2013	25.2	3.9	41	162,519
2012	27.7	4.1	45	162,427
2011	30.3	4.3	50	165,114
2010	26.9	4.0	45	167,533
2009	31.5	4.3	53	168,494

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2017	11.0	2.2	26	235,446
2014_2016	10.9	2.1	26	238,506
2013_2015	9.6	2.0	23	240,137
2012_2014	8.3	1.9	20	242,273
2011_2013	11.4	2.2	28	245,750
2010_2012	11.1	2.1	28	251,412
2009_2011	12.5	2.2	32	256,302
2008_2010	11.6	2.1	30	259,537
2007_2009	10.8	2.0	28	260,274

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2017	13.2	2.4	31	235,446
2014_2016	13.0	2.3	31	238,506
2013_2015	11.2	2.2	27	240,137
2012_2014	8.3	1.9	20	242,273
2011_2013	9.0	1.9	22	245,750
2010_2012	9.5	2.0	24	251,412
2009_2011	11.3	2.1	29	256,302
2008_2010	11.9	2.2	31	259,537
2007_2009	10.8	2.0	28	260,274

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	13.4 %	1.1 %	41,238	308,059
2016	13.6 %	1.3 %	42,109	309,692

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	17.4 %	3.1 %	7,174	41,238
2016	16.7 %	3.2 %	7,021	42,109

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	1.6 %	0.4 %	4,022	254,642
2016	1.8 % ϟ	0.6 % ϟ	4,558 ϟ	257,036 ϟ

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

ϟ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	5.4 %	0.8 %	13,620	253,200
2016	5.0 %	0.7 %	12,754	254,397

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	45.6 % ⚡	6.1 % ⚡	9,601 ⚡	21,033 ⚡
2016	38.4 % ⚡	7.4 % ⚡	8,494 ⚡	22,150 ⚡

Legends:

🏴 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	91.3 %	1.0 %	280,275	307,112
2016	91.7 %	1.2 %	282,105	307,798

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

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

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	10.3 %	0.3 %	1,343	12,987
2012	10.2 %	0.3 %	1,489	14,578
2010	9.7 %	0.3 %	1,413	14,504
2008	10.0 %	0.3 %	1,279	12,796

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	14.2 %	0.6 %	5,507	38,832
2015	12.9 %	1.1 %	5,022	39,032
2013	13.5 %	1.1 %	5,413	40,216
2011	13.1 %	1.3 %	5,482	41,970
2009	14.2 %	1.7 %	6,699	47,219
2007	15.0 %	1.4 %	7,805	51,954
2005	13.0 %	1.0 %	6,777	52,210

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	13.9 %	1.9 %	16,615	119,950
2016	11.0 %	1.9 %	12,738	115,773

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	2.1 %	0.4 %	6,519	304,896
2016	2.1 %	0.4 %	6,484	306,799
2015	1.4 %	0.3 %	4,350	312,071
2014	2.0 %	0.3 %	6,246	307,392
2013	3.2 %	0.6 %	9,896	306,669
2012	2.9 %	0.5 %	8,844	301,575
2011	3.9 %	0.6 %	11,813	304,365
2010	3.7 %	0.6 %	11,134	302,473
2009	2.6 %	0.5 %	7,498	288,177

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	69.8 %	3.5 %	18,046	25,841
2016	75.1 %	3.1 %	19,930	26,535
2015	73.8 %	3.2 %	19,173	25,966
2014	73.7 %	3.3 %	19,437	26,371
2013	66.5 %	4.2 %	17,471	26,291
2012	80.2 %	2.8 %	21,101	26,326
2011	74.8 %	3.7 %	20,233	27,044
2010	63.7 %	3.3 %	17,732	27,823
2009	46.7 %	3.9 %	12,642	27,068

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	61.0 %	2.4 %	173,982	285,051
2016_2017	60.6 %	2.2 %	169,771	280,243
2015_2016	71.8 %	2.0 %	198,006	275,967
2014_2015	74.4 %	1.9 %	206,844	278,016
2013_2014	70.4 %	2.6 %	194,717	276,586
2012_2013	69.7 %	3.3 %	199,548	286,207
2011_2012	66.6 %	4.0 %	178,392	267,854
2010_2011	70.0 % ϟ	6.4 % ϟ	181,808 ϟ	259,726 ϟ
2009_2010	67.3 %	2.4 %	184,988	274,870

Legends:

⚑ Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

ϟ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	69.4 %	3.1 %	55,143	79,470
2016	64.8 %	3.2 %	51,921	80,076
2015	66.8 %	2.9 %	52,911	79,172

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	84.8 %	2.5 %	67,418	79,470
2016	82.2 %	2.6 %	65,799	80,076
2015	79.6 %	2.5 %	63,034	79,172
2014	82.3 %	2.5 %	66,040	80,260
2013	80.2 %	2.7 %	64,200	80,038
2012	74.1 %	3.0 %	61,021	82,379
2011	67.7 %	3.2 %	56,199	83,036
2010	58.1 %	3.2 %	47,269	81,309
2009	46.1 %	3.5 %	36,222	78,650

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	85.9 %	2.4 %	68,294	79,470
2016	75.9 %	2.9 %	60,738	80,076
2015	78.7 %	2.5 %	62,278	79,172
2014	77.7 %	2.7 %	62,358	80,260
2013	75.0 %	3.1 %	60,003	80,038
2012	70.4 %	3.2 %	58,019	82,379
2011	70.2 %	3.0 %	58,282	83,036
2010	64.5 %	3.0 %	52,417	81,309
2009	51.0 %	3.5 %	40,094	78,650

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	19.1	0.7	714	37,287
2016	19.2	0.7	728	37,877
2015	20.7	0.7	789	38,123
2014	23.2	0.8	893	38,413
2013	25.0	0.8	976	39,000
2012	27.9	0.8	1,108	39,717
2011	29.7	0.9	1,199	40,367
2010	32.6	0.9	1,347	41,288
2009	37.0	0.9	1,547	41,755

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	9.0 %	1.1 %	1,610	17,938
2014	11.0 %	1.2 %	1,974	17,970
2013	9.5 %	1.0 %	1,748	18,407
2012	10.6 %	1.0 %	1,938	18,254

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	1.7 %	0.5 %	5,239	305,190
2016	2.7 %	0.8 %	8,400	307,347

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Hawaii

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

Federally Available Data			
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)			
	2016	**2017**	**2018**
Annual Objective	62	63	67
Annual Indicator	63.0	66.7	69.4
Numerator	152,559	161,334	167,372
Denominator	242,088	241,941	241,254
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	70.0	72.0	74.0	76.0	78.0	80.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2019**

Column Name: **Annual Objective**

Field Note:
Objective was updated because we have already met our 2018 objective (67%). Based on the growth pattern demonstrated in the 2015-2017 data and consultation with program staff, the state objectives from 2019 to 2024 reflects an annual increase of 2 percentage points.

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	**2017**	**2018**
Annual Objective	90	91	89
Annual Indicator	90.6	87.3	90.6
Numerator	15,214	15,007	15,313
Denominator	16,789	17,199	16,911
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	91.0	92.0	92.0	93.0	93.0	94.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
Objectives have been updated because we have already met our 2018 objective (89.0%). The annual performance objective through 2024 reflects an approximate 5% improvement over 5 years distributed among the individual years.

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

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	**2017**	**2018**
Annual Objective	27	30	30
Annual Indicator	30.1	30.2	32.9
Numerator	4,828	5,029	5,396
Denominator	16,071	16,662	16,415
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	33.0	33.0	34.0	34.0	35.0	35.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
Objective was updated because we have already met our 2018 objective (30.0%). Based on consultation with program staff, there might be barriers and challenges to exclusively breastfeeding until 6 months, so we estimated an approximate 5% improvement over 5 years for 2019-2024.

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

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2016	2017	2018
Annual Objective	79	79	80
Annual Indicator	79.2	81.5	81.5
Numerator	14,243	14,376	14,376
Denominator	17,975	17,634	17,634
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2015

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	82.0	82.0	83.0	84.0	85.0	86.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
No new PRAMS data is available beyond 2015. Based on the pattern of growth from 2011 (78.1%) to 2015 (81.5%) and consultation with program staff, the annual performance objectives for years 2019-2024 have been updated to reflect an approximate 5% improvement over 5 years distributed among the individual years.

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

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

State Provided Data		
	2017	2018
Annual Objective		
Annual Indicator	100	100
Numerator	1	1
Denominator	1	1
Data Source	1	1
Data Source Year	1	1
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2017**

   Column Name: **State Provided Data**

   Field Note:
   1 is entered because PRAMS 2016 data is not available in State

2. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   1 is entered because PRAMS 2017 data is not available in State

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

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

State Provided Data		
	2017	**2018**
Annual Objective		
Annual Indicator	100	100
Numerator	1	1
Denominator	1	1
Data Source	1	1
Data Source Year	1	1
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 1 is entered because PRAMS 2016 data is not available in State	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 1 is entered because PRAMS 2017 data is not available in State	
3.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**
	Field Note: 1 is entered because data is not available in State	

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

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			33
Annual Indicator		32.0	39.1
Numerator		12,946	14,121
Denominator		40,486	36,113
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	39.0	40.0	41.0	42.0	43.0	44.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
Objective was updated because we have already met our 2018 objective (33.0%). Based on the 2018 baseline data and consultation with program staff, the state objectives from 2019 to 2024 reflect an annual increase of 1 percentage point.

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			74
Annual Indicator		73.5	74.6
Numerator		67,325	74,226
Denominator		91,592	99,470
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	75.0	77.0	79.0	81.0	82.0	83.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
Objective was updated because we have already met our 2018 objective (74.0%). Based on discussion with program staff, the annual performance objective for years 2019-2024 reflects an approximate 10% improvement over 5 years distributed among the individual years.

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	**2017**	**2018**
Annual Objective			23
Annual Indicator		23.3	21.9
Numerator		4,235	4,457
Denominator		18,144	20,375
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	23.0	23.0	24.0	24.0	25.0	25.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2019**

   Column Name: **Annual Objective**

   Field Note:
   Based on discussion with program staff, the annual performance objective for years 2019-2024 reflects an approximate 10% improvement over 5 years distributed among the individual years.

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			84
Annual Indicator		83.1	84.9
Numerator		243,681	242,790
Denominator		293,312	285,950
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	85.0	86.0	87.0	87.0	88.0	89.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2019**

Column Name: **Annual Objective**

Field Note:
The annual performance objective for years 2019-2024 reflects an approximate 5% improvement over 5 years distributed among the individual years.

Form 10
State Performance Measures (SPMs)

State: Hawaii

SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers.

Measure Status:	Active

State Provided Data

	2016	2017	2018
Annual Objective			11
Annual Indicator			
Numerator	8	11	12
Denominator	72	72	72
Data Source	Telehealth work group, Family Health Services Divi	The preliminary 5-year plan objectives were develo	Telehealth work group, Family Health Services Divi
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives

	2019	2020	2021	2022	2023	2024
Annual Objective	13.0	14.0	15.0	16.0	17.0	18.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: The measure is a scale. Converting into percentages the annual indicator would be 8/72 = 11.1%	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The measure is a scale. Converting into percentages the annual indicator would be 11/72 = 15.3%	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: The measure is a scale. Converting into percentages the annual indicator would be 12/72 = 16.7%	
4.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**
	Field Note: Objectives have been updated as the 2018 objective has been met. 2019-2024 objectives are estimated at an annual improvement of 1 point.	

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

Measure Status:	Active

Annual Objectives

	2019	2020	2021	2022	2023	2024
Annual Objective	5.9	5.8	5.8	5.7	5.6	5.6

Field Level Notes for Form 10 SPMs:

1. **Field Name:** **2019**

   Column Name: **Annual Objective**

   Field Note:
   Baseline Data from 2017 DHS CAN annual report (http://humanservices.hawaii.gov/reports/child-abuse-and-neglect-reports/)
   represents a rate of 5.9 per 1,000 children 0-5 years of age (Numerator: 635 unique children confirmed victims; Denominator: 2017 Census Estimate 0-5 years: 108,119). Objectives set at 5% improvement over 5 years spread out over individual years.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Hawaii

ESM 1.1 - Percent of births with less than 18 months spacing between birth and next conception

Measure Status:	Active

State Provided Data			
	2016	**2017**	**2018**
Annual Objective		34	31
Annual Indicator	32.7	31.8	31.9
Numerator	3,020	2,851	2,776
Denominator	9,237	8,975	8,698
Data Source	vital statistics	vital statistics	vital statistics
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	31.0	30.0	30.0	30.0	30.0	30.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Estimate for 2016 revised due to availability of 2016 data; prior year reported 2015 provisional only.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Estimate based on 2017 provisional vital statistics data file as final 2017 data file not available.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Estimate based on 2018 provisional vital statistics data file as final 2018 data file not available

4.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
The annual performance objective for years 2019-2024 reflects an approximate 5% improvement over 5 years distributed among the individual years

ESM 4.1 - Percent of Women, Infants, and Children (WIC) infants ever breastfed

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		81	81
Annual Indicator	80.6	80.6	80.6
Numerator	12,996	12,996	12,996
Denominator	16,132	16,132	16,132
Data Source	HI WIC Services Program	HI WIC Services Program	HI WIC Services Program
Data Source Year	2016	2016	2016
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	82.0	83.0	84.0	85.0	86.0	87.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
The number is obtained for SFY 2016 (July 1,2015 to June 30, 2016).
Numerator: Unduplicated number of WIC infants by SFY 2016
Denominator: Unduplicated number of WIC infants ever breastfed by SFY 2016

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Due to changes in data collection system over the transition completed in May 2017, no comparable data was available to report with this ESM so the 2016 data was carried over to 2017.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Due to changes in data collection system over the transition completed in May 2017, no comparable data was available to report with this ESM so the 2016 data was carried over to 2018.

4.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
The annual performance objective for years 2019-2024 reflects an approximate 5% improvement over 5 years distributed among the individual years.

ESM 5.1 - Percent of birthing hospitals with current protocols that align with the American Academy of Pediatrics' Recommendations for a Safe Infant Sleeping Environment

Measure Status:	Inactive - Completed		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		60	100
Annual Indicator	66.7	91.7	100
Numerator	8	11	
Denominator	12	12	
Data Source	Safe Sleep Hawaii	Safe Sleep Hawaii	Safe Sleep Hawaii
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note:	

ESM 5.2 - The number of languages in which safe sleep educational materials are available for Hawaii's communities.

Measure Status:					Active
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	11.0	11.0	11.0	11.0	11.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
Data will be based on results of the Department of Health Safe Sleep Program; Child Care Program Department of Human Services; and the State Office of Language Access project to translate Safe Sleep educational materials into other languages for use by non-English speakers.

ESM 6.2 - Develop and implement Policy and Public Health Coordination rating scale to monitor developmental screening efforts around the areas of systems development, family engagement, data integration, and addressing vulnerable populations

Measure Status:	Active

Annual Objectives

	2019	2020	2021	2022	2023	2024
Annual Objective	12.0	18.0	24.0	27.0	30.0	30.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
Objectives set by program to reach max scale score of 30 over 5 years.

ESM 10.1 - Development and dissemination of a teen-centered, Adolescent Resource Toolkit (ART) with corresponding continuing education series (Science) to primary care providers to increase knowledge and skill in implementing the adolescent well-care visit

Measure Status:	Inactive - Completed		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective			16
Annual Indicator			
Numerator	13	16	17
Denominator	51	51	51
Data Source	ART and Science Workgroup	ART and Science Workgroup	ART and Science Workgroup
Data Source Year	2016 PRog	2017	2018
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 10.2 - Develop and disseminate a teen-centered, Adolescent Resource Toolkit (ART) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits

Measure Status:	Active

Annual Objectives					
	2020	2021	2022	2023	2024
Annual Objective	18.0	23.0	25.0	28.0	30.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2020**

   Column Name: **Annual Objective**

   Field Note:
   The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2020 objective will be 18/30 = 60.0%.

2. **Field Name:** **2021**

   Column Name: **Annual Objective**

   Field Note:
   The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2021 objective will be 23/30 = 76.7%.

3. **Field Name:** **2022**

   Column Name: **Annual Objective**

   Field Note:
   The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2022 objective will be 25/30 = 83.3%.

4. **Field Name:** **2023**

   Column Name: **Annual Objective**

   Field Note:
   The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2023 objective will be 28/30 = 93.3%.

5. **Field Name:** **2024**

   Column Name: **Annual Objective**

   Field Note:
   The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2024 objective will be 30/30 = 100%.

ESM 12.1 - Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult health care for Youth with Special Health Care Needs (YSHCN), related to Six Core Elements of Health Care Transition 2.0.

Measure Status:	Active

State Provided Data

	2016	2017	2018
Annual Objective			17
Annual Indicator			
Numerator	12	13	18
Denominator	33	33	33
Data Source	Title V Transition Workgroup	Title V Transition Workgroup	Title V Transition Workgroup
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives

	2019	2020	2021	2022	2023	2024
Annual Objective	21.0	24.0	26.0	28.0	30.0	33.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** 2017

   Column Name: State Provided Data

   Field Note:
   The measure is a scale and the annual indicator for 2017 is 13. Converting into percentage 13/33 = 39.4%

2. **Field Name:** 2018

   Column Name: State Provided Data

   Field Note:
   The measure is a scale and the annual indicator for 2018 is 18. Converting into percentage 18/33 = 54.5%

3. **Field Name:** 2019

   Column Name: Annual Objective

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2019 objective will be 21/33 = 63.6%.

4.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2020 objective will be 24/33 = 72.7%.

5.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2021 objective will be 26/33 = 78.8%.

6.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2022 objective will be 28/33 = 84.8%.

7.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 33.Converting into percentage, the 2023 objective will be 30/33 = 90.9%.

8.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**

Field Note:
The objectives for this program are set by program staff. The measure is scale where the denominator is 33.Converting into percentage, the 2024 objective will be 33/33 = 100%.

ESM 13.2.2 - Completion of teledentistry pilot project at three early childhood settings to reach underserved children.

Measure Status:	Inactive - Completed		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		Yes	0
Annual Indicator	No	No	Yes
Numerator			
Denominator			
Data Source	Virtual Dental Home Planning Team	Virtual Dental Home Planning Team	Virtual Dental Home Planning Team
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 13.2.3 - The number of organizations and individuals participating in State Oral Health Coalition meetings and activities

Measure Status:	Active

Annual Objectives					
	2020	2021	2022	2023	2024
Annual Objective	60.0	65.0	70.0	75.0	80.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2020**

   Column Name: **Annual Objective**

   Field Note:
   The objectives for this measure are set by program staff.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Hawaii

SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the use of telehealth across Title V activities to improve access to services and education for families and providers.
Definition:	**Numerator:** Total Actual Scores from three Telehealth Data Collection Forms **Denominator:** Total Possible Scores from three Telehealth Data Collection Forms (18, 24, 30) **Unit Type:** Scale **Unit Number:** 72
Healthy People 2020 Objective:	HP2020 Health Communication & Health Information Technology Goal: Use health communication strategies and health information technology (IT) to improve population health outcomes and health care quality, and to achieve health equity.
Data Sources and Data Issues:	This is a summary of the Data Collection Form that lists 24 strategy components organized by the three areas in telehealth activities: • Infrastructure development • Training/education development • Service development Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 72. Scoring is completed by FHSD staff. The data collection form is attached as a supporting document.
Significance:	With the reduction in personnel resources, increases in travel costs, and availability of high speed internet and affordable devices, telehealth can be one of the tools to increase access to families and providers while saving costs and travel time. Telehealth can be used to increase access to services for families, care coordination activities, education for providers, and workforce training for public health staff.

SPM 4 - Rate of confirmed and child abuse and neglect reports per 1,000 for children aged 0 to 5 years.
Population Domain(s) – Child Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Reduce the rate of child abuse and neglect with special attention on ages 0-5 years.</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Numerator:</td><td>Number of confirmed Child Protective Services reports of abuse and neglect for children aged 0 to 5 years</td></tr>
<tr><td>Denominator:</td><td>Number of children aged 0 to 5 years in the state based on decennial census (2010 data reported 104,333 children)</td></tr>
<tr><td>Unit Type:</td><td>Rate</td></tr>
<tr><td>Unit Number:</td><td>1,000</td></tr>
</table></td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>Related to: IPV-37 Reduce child maltreatment deaths to 2.1 deaths per 100,000 children under age 18 years. Baseline: 2.3 child maltreatment deaths per 100,000 children under age 18 years occurred in 2008.
IPV-38: Reduce nonfatal child maltreatment to 8.5 maltreatment victims per 1,000 children under age 18 years. Baseline: 9.4 victims of nonfatal child maltreatment per 1,000 children under age 18 years were reported in 2008.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Hawaii Department of Human Services, Management Services Office. Child Abuse and Neglect Annual reports</td></tr>
<tr><td>Significance:</td><td>Child abuse and neglect has pervasive effects over a person's lifetime. Abuse has negative effects not only on physical health but also on mental, emotional and social health of individuals.</td></tr>
</table>

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Hawaii

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Hawaii

ESM 1.1 - Percent of births with less than 18 months spacing between birth and next conception
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To support reproductive life planning and healthy birth outcomes by increasing intervals of birth spacing (births spaced from 18 month to next conception).
Definition:	**Numerator:** Number of Births with interval < 18 months between birth and next conception **Denominator:** Total number of Births **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data source is vital statistics, Office of Health Status Monitoring. Calculation of interval is based on birth certificate data with valid clinical estimate of gestational age of index birth and prior live birth. Pregnancy Interval = ConceptionDate – Last Live Birth (following HRSA CoIIN to reduce infant mortality outcome measure).
Significance:	Research shows that effective contraception can help with birth spacing, reduce the risk of low-weight and premature births, and support a woman's longer term physical and emotional well-being. The Centers for Disease Control and Prevention has identified Long Acting Reversible Contraception (LARC) as among the most effective family planning methods with a pregnancy rate of less than 1 pregnancy per 100 women in the first year. LARC's intrauterine devices (IUDs) and contraceptive implants are highly effective methods of birth control and can last between 3 and 10 years (depending on the method). Incorporating pregnancy intention screenings in routine and proactive settings where reproductive health age women are likely to be screened every 3 months to a year, regardless of the reason for a women's visit supports the use of One Key Question®(OKQ) and multiple opportunities for these interventions with discussions that can lead to opportunities for preconception care and contraceptive services. References: Department of Health and Human Services, Centers for Medicaid and Medicaid Services, CMCS Informational Bulletin, April 8, 2016, State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception; Augustin Conde Agueldo, MD, MPH; Anyeli Rosas-Bermudez, MPH; Ana Cecilia Kafury-Goeta, MD (2006). Birth Spacing and Risk of Adverse Perinatal Outcomes: A Meta-analysis. JAMA 295 (15): 1809-1823. Trussell J. Contraceptive efficacy. In: Hatcher R, Trussell J, Nelson A, Cates W, Kowal D, Policar M, eds. Contraceptive Technology. 20th ed. New York, NY: Ardent Media; 2011:779-863. Oregon Foundation for Reproductive Health One Key Question®.

ESM 4.1 - Percent of Women, Infants, and Children (WIC) infants ever breastfed
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Promote Breastfeeding in all WIC clinics statewide
Definition:	**Numerator:** Unduplicated number of WIC infants ever breastfed by SFY **Denominator:** Unduplicated number of WIC infants by SFY **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Hawaii WIC Program Data
Significance:	Breastfeeding is the normative standard for infant feeding and nutrition and can result in improved infant and maternal health outcomes. Given the indisputable short- and long-term advantages of breastfeeding, infant nutrition is considered a public health priority. The American Academy of Pediatrics (AAP) recommends that all infants be exclusively breastfed for about six months with continuation of breastfeeding for one year or longer. Breastfeeding is also encouraged and supported by other agencies such as the United States Department of Agriculture's (USDA) Food and Nutrition Service (FNS). However, as rewarding as breastfeeding can be, some women choose not to breastfeed and many women who start breastfeeding often stop when they are faced with challenges. With appropriate guidance and education, women can overcome these obstacles and continue breastfeeding for longer periods. WIC is the largest public breastfeeding promotion program in the state and nation, providing mothers with education and support as a core service. Moreover, promoting and/or facilitating community activities that reinforce breastfeeding may allow for more women across the state to have access to the support they need to initiate breastfeeding and continue doing so exclusively for at least 6 months.

ESM 5.1 - Percent of birthing hospitals with current protocols that align with the American Academy of Pediatrics' Recommendations for a Safe Infant Sleeping Environment
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Inactive - Completed
Goal:	Educate mother and family to maintain a safe sleep position & environment for infants.
Definition:	**Numerator:** Number of birthing hospitals with current AAP safe sleep protocols **Denominator:** Total number of birthing hospitals **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Safe Sleep Hawaii
Significance:	About 3,500 US infants die suddenly and unexpectedly each year. Theese deaths are referred to as sudden unexpected infant deaths (SUID). SUID are one of the three leading causes of death among infants nationally and in Hawaii (Hayes DK, Calhoun CR, Byers TJ, Chock LR, Heu PL, Tomiyasu DW, Sakamoto DT, and Fuddy LJ. Saving Babies: Reducing Infant Mortality in Hawaii. Hawaii Journal of Medicine and Public Health. 2013. 72 (2): 246-251). Although the causes of death in many of these children can't be explained, most occur while the infant is sleeping in an unsafe sleeping environment. The American Academy of Pediatrics (AAP) expanded their recommendation to focus on safe sleep environments to reduce sleep related infant deaths. One recommendation is directed towards health care professionals, including staff in newborn nurseries and the NICU (AAP, 2011). Ensuring that current and consistent messages are provided by hospital staff to mothers in the hospital can influence infant safe sleep practices.

ESM 5.2 - The number of languages in which safe sleep educational materials are available for Hawaii's communities.
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Expand outreach to Non-English-speaking families and care givers through translation of educational and general awareness safe sleep messages.
Definition:	**Numerator:** Number of languages Departments of Health (DOH) & Human Services (DHS) safe sleep are available for Hawaii's communities **Denominator:** N/A **Unit Type:** Count **Unit Number:** 20
Data Sources and Data Issues:	Data will be collected by Safe Sleep Hawaii about the efforts by DOH, DHS and the State Office of Language Access to translate educational materials into other languages for use by non-English speakers.
Significance:	About 3,500 US infants die suddenly and unexpectedly each year. These deaths are referred to as sudden unexpected infant deaths (SUID). SUID is one of the three leading-causes of death among infants nationally and in Hawaii (Hayes DK, Calhoun CR, Byers TJ, Chock LR, Heu PL, Tomiyasu DW, Sakamoto DT, and Fuddy LJ. Saving Babies: Reducing Infant Mortality in Hawaii. Hawaii Journal of Medicine and Public Health. 2013. 72 (2): 246-251). The American Academy of Pediatrics (AAP) recommends a safe sleep environment to reduce the risk of all sleep-related infant deaths. AAP recommendations for a safe sleep environment include supine positioning, the use of a firm sleep surface, room-sharing without bed-sharing, and the avoidance of soft bedding and overheating. Additional recommendations for SUID reduction include the avoidance of exposure to smoke, alcohol, and illicit drugs; breastfeeding; routine immunization; and use of a pacifier. The AAP recommends education should include all who care for infants, including parents, child care providers, grandparents, foster parents, and babysitters, and should include strategies for overcoming barriers to behavior change. Research on health education and SUID outreach has found that response to safe sleep messages differed among different communities and racial/ethnic groups, which may help explain some of the lingering differences in SUID rates. Therefore, campaigns should have a special focus on getting safe sleep messages to parents and caregivers in diverse communities because of the higher incidence of SUID and other sleep-related infant deaths in these groups.

ESM 6.2 - Develop and implement Policy and Public Health Coordination rating scale to monitor developmental screening efforts around the areas of systems development, family engagement, data integration, and addressing vulnerable populations
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the number of children receiving developmental screening and referred and receiving services among Hawaii Title V direct service programs.
Definition:	**Numerator:** Total scale score based on program assessment of 10 steps **Denominator:** 30 **Unit Type:** Scale **Unit Number:** 30
Data Sources and Data Issues:	Program Data. The ESM 6.2 is using the Hawaii Title V Developmental Screening Workgroup's Policy and Public Health Coordination (PPHC) rating scale to monitor infrastructure development on developmental screening and services within FHSD. It will be a self-assessment of the team's efforts to improve efforts to develop the infrastructure for FHSD screening and services and will be measured annually.
Significance:	The PPHC will help measure Hawaii's efforts to improve the service delivery and systems development for developmental screening with the end goal of all the strategies and activities completion will signify that the system has been developed. A Policy and Public Health Coordination Scale (PPHCS) has been created to monitor/track progress made on the 5-Year plan strategies for developmental screening. The Title V Screening Workgroup will complete the scale annually starting in FFY 2019 as part of routine evaluation. Element 0 --Not met 1--Partially Met 2--Mostly Met 3--Completely Met Systems Development 1. Develop guidelines and toolkit for screening, referral and services. 2. Work with partners to develop infrastructure for ongoing training, technical assistance, and support for providers conducting developmental screening activities. Family Engagement and Public Awareness 3. Work with families and parent organizations to develop family-friendly material explaining importance of developmental screening and how to access services. 4. Develop website to house materials, information and resources on developmental screening. Data Collection and Integration 5. Develop data system for internal tracking and monitoring of screening, referral, and services data. 6. Develop process for on-going communication to review data findings and make adjustments for better outcomes for children and families Policy and Public Health Coordination 7. Develop Policy and Public Health Coordination Scale. 8. Conduct process for annual assessment of rating scale.

	Social Determinants of Health and Vulnerable Populations 9. Develop process for identifying vulnerable populations. 10. Work with stakeholders to address supports and targeted interventions for vulnerable populations

ESM 10.1 - Development and dissemination of a teen-centered, Adolescent Resource Toolkit (ART) with corresponding continuing education series (Science) to primary care providers to increase knowledge and skill in implementing the adolescent well-care visit
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Inactive - Completed</td></tr>
<tr><td>Goal:</td><td>Increase resources, training and practice improvement support for adolescent health providers to provide well-care visits aligned to Bright Futures.</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Numerator:</td><td>Numerator: Total Actual Score from Adolescent Health Data Collection Form</td></tr>
<tr><td>Denominator:</td><td>Denominator: Total Possible Score from Adolescent Health Data Collection Form</td></tr>
<tr><td>Unit Type:</td><td>Scale</td></tr>
<tr><td>Unit Number:</td><td>51</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>This is a summary of the Data Collection Form that lists 17 strategy components organized by the following domains:
• Adolescent Resource Toolkit
• Continuing Education Curriculum Series (Science)
• Outreach and Training
Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 51. Scoring is completed by Title V staff, with input from ART & Science Workgroup. The data collection form is attached as a supporting document.</td></tr>
<tr><td>Significance:</td><td>Many health plan, provider, parent and adolescent challenges exist which limit access to comprehensive adolescent well care (AWC) visits which include:
• Poor utilization of AWC
• Perception that the AWC lacks value
• Variability in health plan benefit cost share for families of the AWC and follow up services
• High utilization of sports physicals instead of AWCInconsistent practices addressing confidentiality
• Provider discomfort with mental health, substance abuse, and reproductive health interventions
• Lack of knowledge of community resources

Teen-centered care includes:
• Teens' contraceptive and reproductive health needs are assessed at every visit e.g. emergency contraception is available to male and female adolescents.
• Teens receive STD/HIV counseling, testing, and treatment without having an exam.
• Mental health, substance use, violence, and other health concerns are assessed and appropriate referrals are made.
• Health information disclosed or discussed during a visit is confidential, consistent with state laws and regulations.
• Billing procedures maintain teen's confidentiality.
• The health center environment and staff leave teen patients feeling respected and engaged in their health care.</td></tr>
</table>

	• Culturally competent care is provided, and care is sensitive to and respectful of each teen’s culture, ethnicity, community values, religion, language, educational level, sex, gender, and sexual orientation. • The care provided addresses the unique biologic, cognitive, and psychosocial needs of adolescents. • Conversations between teens and providers are two-way, where teens feel respected and not judged. Everyone knows there‘s an “ART & Science” in supporting adolescents. Title V will address the documentation of practices and resources through it‘s “ART” and provide the “Science” support through continuing education training.

ESM 10.2 - Develop and disseminate a teen-centered, Adolescent Resource Toolkit (ART) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Increase resources, training and practice improvement support for adolescent health and service providers to promote wellness and healthcare visits aligned to Bright Futures.
Definition:	**Numerator:** Total Actual Score from Adolescent Health Data Collection Form **Denominator:** Total Possible Score from Adolescent Health Data Collection Form (30 total) **Unit Type:** Scale **Unit Number:** 30
Data Sources and Data Issues:	This is a summary of the Data Collection Form that lists 10 strategy components organized by the following domains: • Collaboration • Engagement to Develop the Adolescent Resource Toolkit • Workforce Development Training for Community Stakeholders Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 30. Scoring is completed by Adolescent Health staff, with input from key partners.
Significance:	Adolescence is a period of major physical, psychological and social development and the initiation of risky behaviors as teens move from childhood toward adulthood. Teens assume individual responsibility for health habits. An annual preventive well visit may help teens adopt or maintain health habits and behaviors and avoid health damaging behaviors. The Bright Futures guidelines recommend that teens have an annual checkup from age 11-21 years, however many do not. Barriers include: • Lack of awareness of guidelines • Perception that the AWC lacks value • Unaware or variability of insurance coverage and follow up services • High utilization of sports physicals instead of AWC • Inconsistent practices addressing confidentiality • Lack of medical home • Lack of knowledge of community resources. The ART and collaboration with community/youth service providers will help to address many of these barriers and build the knowledge base of professionals working with youth.

ESM 12.1 - Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult health care for Youth with Special Health Care Needs (YSHCN), related to Six Core Elements of Health Care Transition 2.0.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	To increase the degree to which the Title V CYSHNS promotes and/or facilitates transition to adult health care for YSHCN.
Definition:	**Numerator:** Total Actual Score from Transition to Adult Health Care Data Collection Form **Denominator:** Total Possible Score from Transition to Adult Health Care Data Collection Form (33) **Unit Type:** Scale **Unit Number:** 33
Data Sources and Data Issues:	This is a summary of the Data Collection Form that lists 11 strategy components organized by the Six Core Elements of Health Care Transition: • Transition policy • Transition tracking and monitoring • Transition readiness • Transition planning • Transfer of care • Transition completion. Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 33. Scoring is completed by CSHNP staff, with input from Hilopaa Family to Family Health Information Center. The data collection form is attached as a supporting document.
Significance:	CYSHNS is addressing Got Transition's Six Core Elements of Health Care Transition 2.0. Strategy components were adapted for integration as part of CYSHNS services to support youth/families in preparing for transition to adult health care. Health and health care are important to making successful transitions. The majority of YSHCN do not receive needed support to transition from pediatric to adult health care. In addition, YSHCN, compared to those without special health care needs, are less likely to complete high school, attend college, or be employed. The Title V CYSHNS has been addressing these barriers through providing general transition information to families receiving CYSHNS /clinic services or attending transition-related community events, and leading/participating in planning Transition Fairs. The next phase is CYSHNS working to improve its direct services with youth/families related to transition to adult health care, using an evidence-informed quality improvement approach. The Six Core Elements of Health Care Transition is an evidence-informed model for transitioning youth to adult health care providers that has been developed and tested in various clinical and health plan settings. They were developed by the Got Transition/Center for Health Care Transition Improvement, based on the joint clinical recommendations from the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), and American College of Physicians (ACP). References: Got Transition, "Side-By-Side Version, Six Core Elements of Health Care Transition 2.0"; AAP, AAFP, ACP, "Clinical Report – Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home", Pediatrics 2011;128:182-200; McPheeters M et al., "Transition Care for Children With Special Health Needs", Technical Brief No. 15. Agency for Healthcare Research and Quality (AHRQ) Publication No. 14-EHC027-EF, June 2014.

ESM 13.2.2 - Completion of teledentistry pilot project at three early childhood settings to reach underserved children.
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Inactive - Completed
Goal:	Demonstrate the feasibility and effectiveness of teledentistry to improve the oral health of children.
Definition:	**Numerator:** Number of programs participating **Denominator:** WIC, Head Start, & Tutu & Me pre-school participation **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	The process to complete year one of the 3-year project involves several key steps: 1. Demonstrate need for project and barriers/facilitators that exist 2. Educate and inform community oral health stakeholders and others about the teledentistry delivery of care system and applications to Hawaii 3. Develop planning committee for teledentistry projects 4. Develop proof of concept for teledentistry projects 5. Secure funding for three year pilot project 6. Develop program orientation for community partners, providers, and site staff to introduce concept 7. Identify locations and execute Memorandum of Understanding with three pilot sites 8. Develop program protocols and policies and procedures for both dental services and case management 9. Develop consents and other communications to parents 10. Purchase dental equipment and computer software 11. Provide necessary training for providers and site staff 12. Develop evaluation plan including economic feasibility analysis 13. Teledentistry operational at three sites 14. Conduct evaluation and program improvement 15. Provide adequate case management to ensure participants establish a dental home 16. Inform public of project results, lessons learned, and future considerations The measure will be answer “Yes” when all 16 activities are completed. The Department of Health Teledentistry Planning Committee will determine the data for this measure. No data issues are anticipated.
Significance:	For children and adults, regular dental visits allow for the provision of preventive services and the detection of oral disease at an early stage. Unfortunately, only 71% of low-income children and 52% of low-income adults saw a dentist during the past year. Medicaid enrolled children in Hawaii continue to lag behind in cost-effective preventive measures, such as dental sealant placement. Oral health care during pregnancy can be done safely and effectively at all stages of pregnancy, however only 41% of pregnant women in Hawaii reported seeing a dentist during their pregnancy. Disparities remain by county, educational status, low-income and Medicaid

insured.

These documented oral health needs highlights the importance of improving accessibility to diagnostic and preventive measures to improve the oral health of Hawaii children and pregnant women. Teledentistry can provide diagnostic and preventive dental services for underserved populations that traditionally delay care until they have advanced disease, pain, and infection. Preventive services may be more readily available when provided by hygienists in a public health setting. Dentists are not required to leave the clinic setting but through ‘store and forward’ technology, have the ability to diagnose on their own time, while not delaying the timely preventive interventions that can be provided by hygienists at lower cost. With radiographs and photographs, dentists are able to diagnose conditions remotely while patients receive preventive services in a timely manner. Diagnosis through teledentistry allows for referral of patients in a timely manner and reduces the costs associated with the “high cost dental suite.”

ESM 13.2.3 - The number of organizations and individuals participating in State Oral Health Coalition meetings and activities
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	To improve the oral health of children.
Definition:	**Numerator:** Not Applicable **Denominator:** Not Applicable **Unit Type:** Count **Unit Number:** 80
Data Sources and Data Issues:	Hawaii Children's Action Network Roster for State Oral Health Coalition
Significance:	Cavities (also known as caries or tooth decay) are one of the most common chronic diseases of childhood in the United States. Untreated cavities can cause pain and infections that may lead to problems with eating, speaking, playing, and learning. Children who have poor oral health often miss more school and receive lower grades than children without disease. The good news is that most tooth decay is preventable when children have access to evidence-based prevention strategies. To prevent tooth decay, the American Academy of Pediatrics recommends several strategies for enhancing the oral health of young children including: parent/family education on oral health (particularly eating nutritious foods and limiting sugars, and brushing teeth with a toothpaste containing fluoride); first preventive visit to a dentist within six months of the first tooth erupting and no later than age 1, with preventive check-ups thereafter; a series of topical fluoride applications to children's teeth; and drinking fluoridated water. With limited access for fluoridated water, a 2015 survey of Hawaii third graders documented some of the highest rates of decay in the U.S. To address this complex issue, a multi-faceted team and approach are needed which span across different settings and systems. Community collaboration and capacity, with representation across different public and private sectors, can help to address the complex issue of child oral health from multiple angles.

Form 11
Other State Data

State: Hawaii

The Form 11 data are available for review via the link below.

Form 11 Data