Maternal and Child Health Services Title V Block Grant

Hawaii

FY 2018 Application/ FY 2016 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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GOVERNOR OF HAWAII

VIRGINIA PRESSLER, M.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 14, 2017

Michael C. Lu, M.D.
Associate Administrator
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, 18W
Rockville, Maryland 20857

Dear Dr. Lu:

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) 2018 (October 1, 2017 – September 30, 2018). The FY 2018 application and FY 2016 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,

Virginia Pressler

Virginia Pressler, M.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

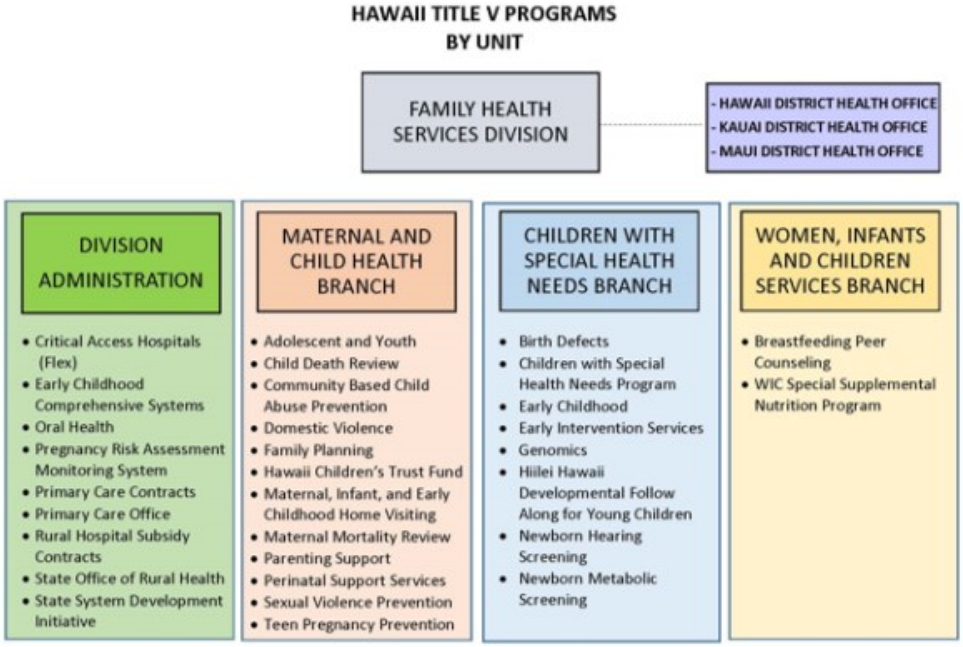
The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

The Family Health Services Division (FHSD) of the Hawaii State Department of Health (DOH) 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, with health equity, social determinants of health, and multi-generational approaches. FHSD has 3 branches–Maternal and Child Health (MCH), Children with Special Health Needs, and Women, Infants & Children (WIC) Services–which together comprise 28 programs, 23 grants, approximately 150 contracts, and 317 FTE positions. FHSD receives approximately $2.2 million each year from Title V (Maternal and Child Health Services Block Grant), which is part of the federal Social Security Act.



Hawaii State Title V Five Year Plan

FHSD completed a statewide needs assessment and selected 11 priorities. Priorities were selected based on:

- Data reflect a need and opportunity for improvement
- FHSD could take a lead or major role for the issue
- FHSD has capacity/resources (staffing and funding) to address the issue
- Community concern and opportunity to align efforts with existing groups

During the past year, FHSD staff developed evidence-based/informed strategy measures and state performance measures for each priority (see table). Accomplishments, challenges, and plans for priority areas are summarized below.

HAWAII STATE TITLE V PRIORITIES & MEASURES FOR 2016-2020		
Domain	**Title V Priority**	**Measure***
Women/ Maternal Health	Promote reproductive life planning	ESM 1.1 – Percent of births with less than 18 months spacing between birth and next conception
Perinatal/ Infant Health	Reduce infant mortality through breastfeeding	ESM 4.1 – Percent of WIC infants ever breastfed
	Reduce infant mortality through safe sleep	ESM 5.1 – Percent of birthing hospitals with current American Academy of Pediatrics safe sleep protocols
Child Health	Improve percentage of children age 0-5 years screened early and continuously for developmental delay	ESM 6.1 – Development and implementation of Data sharing system for FHSD programs conducting developmental screening, referrals, and services
	Reduce rate of child abuse and neglect with special attention on ages 0-5 years	ESM 7.1 – Percent of children in a home visiting program with an injury-related visit to the emergency department since enrollment
		ESM 7.2 – Number of participants who attend trainings and receive technical assistance on promoting safe, healthy, and respectful relationships
Adolescent Health	Improve the development, health, safety, and well-being of adolescents	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 skills in implementing the adolescent well-care visit
Children & Youth with Special Health Care Needs	Promote transition to adult health care	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
Life Course	Improve oral health of children and pregnant women	ESM 13.1 – Establishment of leadership for the State Oral Health Program under the direction of a dental professional and staff with public health skills
		ESM 13.2 – Completion of teledentistry pilot project at three early childhood settings to reach underserved children and pregnant women
	Increase use of telehealth across Title V activities to improve access to services and education for families and providers	SPM 1 – Degree to which Title V programs utilize telehealth to improve access to services and education for families and providers
	Improve family and consumer engagement in Title V programs	SPM 2 – Percent of FHSD staff that have increased their knowledge on family/consumer engagement
	Improve partner engagement in FHSD	SPM 3 – Percent of FHSD staff that have increased their knowledge on partner engagement

*ESM = Evidence-based/informed Strategy Measure
SPM = State Performance Measure

DOMAIN: WOMEN/MATERNAL HEALTH

Promote reproductive life planning

Accomplishments: The Hawaii Maternal and Infant Health Collaborative (HMIHC) continues to promote the use of the One Key Question® (OKQ®) screening approach and Long Acting Reversible Contraception (LARC), both evidence based/informed CoIIN strategies. OKQ® trainings were conducted for clinical/non-clinical providers statewide who serve women of reproductive age. HMIHC works with the State Medicaid program to support the use of OKQ® and eliminate system barriers that limit access to LARC. The Hawaii DOH Strategic Plan 2015-2018 includes OKQ® as a screening protocol and access to LARC when desired.

Challenges: Acquiring timely data to monitor project benchmarks. Staff to oversee OKQ® implementation. Provider barriers to LARC such as device insurance coverage and on-site proctor insurance training for inexperienced providers.

Plans: Continue OKQ® training to address ongoing training needs. Analysis of OKQ® data. HMIHC pre-interconception work group will focus on public awareness and messaging on healthy behaviors to support preventive women's health visits and reproductive life planning.

DOMAIN: PERINATAL/INFANT HEALTH

Reduce infant mortality through promoting breastfeeding

Accomplishments: HMIHC identified breastfeeding promotion as important to improving birth outcomes and reducing infant mortality. WIC provides mothers with education and support and has a Breastfeeding Coordinator. WIC Breastfeeding Peer Counselor Project conducts monthly group sessions for pregnant and breastfeeding WIC moms. WIC participates in the State Breastfeeding Coalition which co-sponsored a Secrets of Baby Behavior Train the Trainer Workshop on infant-feeding practices.

Challenges: Infrastructure for coordination of statewide breastfeeding efforts including lack of data source to measure short-term goals. Birthing facilities improving in appropriate use of breastfeeding supplements however need inclusion of model breastfeeding policies, hospital discharge planning support, assessment of staff competency.

Plans: Strengthen programs that provide mother-to-mother support and peer counseling. Develop state breastfeeding strategic plan and request for endorsements from stakeholders. Support efforts to improve hospital breastfeeding policies and practices.

Reduce infant mortality through promoting safe sleep

Accomplishments: Hospital safe sleep policies reviewed, training resources identified, and development of messaging underway. Safe Sleep integrated into HMIHC's strategic plan. HMIHC/Safe Sleep Hawaii (SSH) partner in national IM ColIN meeting to select evidence based strategies and in 2016 successfully pass Act 203 to reinstitute Child Death Review (CDR). CDR provides critical data on sleep related infant deaths. Statewide CDR training was held for stakeholders, staff, and CDR council members.

Challenges: Practice of co-sleeping among local families, which may be related to ethnicity/culture and small or multi-family living arrangements due to high housing costs. Providing safe sleep education that engages parents in making informed decisions on creating a safe environment.

Plans: Review all birthing hospital policies and training needs. Increase infant safe sleep environment knowledge for caregivers. Collect information on co-sleeping beliefs/behaviors among diverse cultures in Hawaii. Continue safe sleep training of professionals working with new parents. Work with perinatal nurse managers to assess hospital protocols.

DOMAIN: CHILD HEALTH

Promote Developmental Screenings and Services

Accomplishments: FHSD coordinated with various initiatives including the Early Learning Action Strategy workgroup to establish a universal screening-referral-utilization system, Collective Impact public/private partnership which included a developmental screening focus, Maternal Infant and Early Childhood Home Visiting (MIECHV) developmental screening efforts, and FHSD Developmental Screening Workgroup on internal coordination. Hawaii received federal Early Childhood Comprehensive Systems funding for 2016-2021 to conduct developmental screening of 3-year-olds on Maui Island.

Challenges: Need integrated developmental screening system to ensure there are available supports statewide and in each community. Lack of detailed EPSDT data on screening. Need infrastructure support including training and data systems.

Plans: Develop guidelines and toolkit for early childhood providers and health professionals on developmental screening, referral, and services. Work with families and parent organizations to develop family-friendly materials on the importance of screening. Develop an internal data sharing system for FHSD programs. Develop infrastructure for developmental screening, referral, and services for children in DOH programs.

Prevent Child Abuse and Neglect (CAN)

Accomplishments: FHSD program partners (Home Visiting, Parenting Support, Sexual Violence Prevention, Domestic Violence Prevention) created a strategic training approach, based on Adverse Childhood Experiences (ACEs) to prevent child abuse/neglect. FHSD hosted ACEs trainings for multi-disciplinary/agency audiences on Oahu/Kauai on how violence impacts children's brain development and health over the lifespan. National models

encourage healthy relationships and address root causes of ACEs using coordinated, multidisciplinary approaches.

Challenges: Statewide training for multi-disciplinary/agencies takes time and resources. Different FHSD funding streams challenge collaboration due to varying purposes, reporting, data collection requirements.

Plans: FHSD will focus on Adverse Childhood Experience (ACE) training and promote safe, healthy, and respectful relationships over five years. Statewide training/technical assistance will be provided to State and County partners. State and County programs will be encouraged to include ACEs and healthy relationships in program planning to prevent CAN.

DOMAIN: ADOLESCENT HEALTH

Promote Adolescent Well-Being

Accomplishments: Completed literature review, focus groups with adolescents and primary care providers (PCP) to finalize training topics on the unique health care needs of adolescents and the implementation of the adolescent wellness visits (AWV). Conducted lunch time webinars with pediatric specialists for providers on AWV. Act 185 passed by Legislature which requires all youth entering the 7th grade to have a physical examination.

Challenges: Securing adequate resources (staff, funding, leadership) to assure progress. Community health care transformation activities may compete for primary care providers' interest and time.

Plans: Partner with Hawaii Maternal Child Health Leadership Education in Neurodevelopmental & Related Disabilities (MCH LEND) and Hilopaa Family to Family Health Information Center (F2FHIC) to continue ongoing provider webinars on adolescent wellness care. Increase resources, training and practice improvement support for adolescent health providers to provide teen-centered, well-care visits aligned to Bright Futures. Support implementation of Act 185.

DOMAIN: CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

Promote transition to adult health care

Accomplishments: Children and Youth with Special Health Needs Section (CYSHNS) began to address all components of the evidence-based Six Core Elements of Health Care Transition, in working to incorporate transition planning in CYSHNS service coordination for CYSHNS-enrolled youths and their families. Education and public awareness on transition to adult health care was provided at Transition Fairs, parent/special needs conferences, and other events, in collaboration with other state and community partners.

Challenges: Finding a feasible approach to incorporating transition planning in CYSHNS service coordination that considers the range of youth/family situations and service needs, and staff time and caseloads.

Plans: Continue work to incorporate transition planning in CYSHNS service coordination. Continue to provide education and public awareness on transition to adult health care at fairs, conferences, and other events, in collaboration with partners. Continue participation in other transition-related planning efforts that include life course, person-centered planning, referrals for adult services, and long-term services and supports.

DOMAIN: CROSS-CUTTING OR LIFE COURSE

Improve oral health

Accomplishments: FHSD has a 5-Year CDC oral health state infrastructure building grant. Efforts are focused on establishing staff positions, building data surveillance, promoting evidence-based practices including a school dental sealant piolt project and a teledentistry pilot project at early child settings.

Challenges: Difficulty filling oral health program staff positions which impacts progress to develop a coordinated system of care and promote evidence-based practices.

Plans: Fill the oral health positions to assure leadership for the state oral health program; building oral health data surveillance, complete environmental scan to inform state planning; promote evidence-based strategies; teledentistry pilot project in WIC/Head Start; support coalition-building/partnerships to assure broad participation in state oral health planning.

Improve access to services & education through telehealth

Accomplishments: FHSD is implementing or increasing telehealth activities for genetics, newborn screening, early intervention, and home visiting activities. Telehealth workforce training is being developed. Project ECHO Hawaii utilizes videoconferencing to build primary care workforce capacity while improving patient access to specialty health care in rural communities. FHSD is supporting a teledentistry pilot project on Hawaii Island.

Challenges: Programs/staff learning and using new skills and tools for services and education.

Plans: Telehealth infrastructure development–develop and implement policies/procedures for telehealth, develop network of telehealth sites and personnel.

Workforce development–develop curriculum to train staff on using telehealth, implement and evaluate training to improve curriculum.

Service provision–identify services to be provided using telehealth, pilot programs, expand successful pilot programs.

Education/Training–identify education and training to be provided using telehealth, pilot programs, expand successful pilot programs.

Engage families & consumers as partners with FHSD

Accomplishments: FHSD held Focus Group staff training with information on working with families and collecting input to inform public health practice. FHSD continued supporting the Parent Leadership Training Institute for parent leaders. Hawaii Directors of Health and Human Services adopted Ohana Nui ("Extended Family") with a multi-generational approach for engaging families. FHSD recognized the need to include family and consumer partners for improved health outcomes creating the state Title V measure.

Challenges: Develop FHSD infrastructure/policy to support family and consumer engagement: address barriers to provide stipends for parents to attend meetings; scheduling meetings to ensure families/consumers can attend; workforce training on consumer engagement.

Plans: Convene agency and community stakeholders to develop strategies/work plan, inventory FHSD program efforts in family/consumer engagement, initiate Plan-Do Study Act cycles for early adopters to evaluate engagement and refine processes, develop FHSD engagement guidelines, review national resources for best practices, conduct training.

Increase meaningful partnerships with FHSD

Accomplishments: FHSD recognizes the importance of improving partnerships to improve outcomes for children and families creating the state Title V measure.

Challenges: Defining partners and supporting staff to see the value in partnership development. Critically looking at FHSD programs and how they engage partners; programs seeing value in improving partnerships; staff and partner willingness/time to change and engage.

Plans: Focus on collaboration, education, and staff development. Complete assessment to identify key partners for Title V priorities. Identify best practices for partnering and utilize in workforce training. Work with partners to study and implement the "meaningful partnership continuum". Bring new partners to FHSD programs.

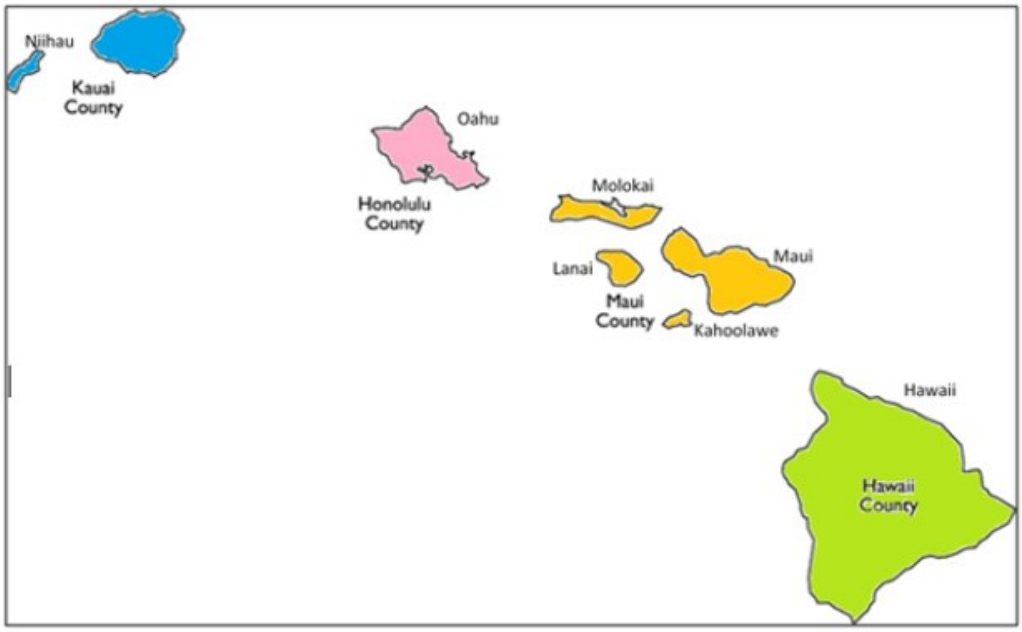
II. Components of the Application/Annual Report

II.A. 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.

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 must 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

According to the U.S. Census Bureau, the estimated 2016 state population has increased slightly, but the distribution of residents has remained largely the same. Oahu (992,605 residents) continues to be the home of nearly three-fourths (69.5%) of the state's population (1,428,469 residents), while 13.9% live on the Big Island (198,449 residents), 11.6% (165,386 residents) in Maui County, and 5.0% (72,029 residents) in Kauai County. From 2010 to 2016, the U.S. Census Bureau estimated an overall growth in the state of 5.0%: 7.4% on the county of Kauai, 6.8% on the county of Maui, 7.2% on the county of Hawaii, and 4.1% on 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 2015 American Community Survey (ACS) 1-year estimates, 24.4% of the population reported two or more races, and the following single race proportions (White=26.0%, Asian=37.1%, Native Hawaiian or Other Pacific Islander (NHOPI)=9.4%, Black=2.1%, and American Indian/Alaskan Native=0.3%). The largest Asian single race sub-groups were Filipino (14.9%), and Japanese (11.9%) and the largest NHOPI single race sub-group was Native Hawaiian (6.0%). The individual Asian and NHOPI sub groups are listed in table and demonstrate 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	372,252	26.0%	0
White Alone or in Combination	634,619	44.3%	41.3%
Native Hawaiian or Other Pacific Islander (NHOPI) Alone	134,232	9.4%	0
NHOPI Alone or in Combination	370,528	25.9%	63.8%
Native Hawaiian Alone	*86,425*	*6.0%*	*0*
Native Hawaiian Alone or in Combination	*309,904*	*21.6%*	*72.1%*
Asian Alone	531,268	37.1%	0
Asian Alone or in Combination	797,698	55.7%	33.4%
Filipino Alone	*213,439*	*14.9%*	*0*
Filipino Alone or in Combination	*368,883*	*25.8%*	*42.1%*
Japanese Alone	*170,131*	*11.9%*	*0*
Japanese Alone or in Combination	*308,562*	*21.6%*	*44.9%*
Chinese Alone	*59,311*	*4.1%*	*0*
Chinese Alone or in Combination	*206,637*	*14.4%*	*71.3%*

Source: U.S. Census Bureau. 2015 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, 2015 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 21.6% of the state population when reported as "alone or in combination," compared to just 6.0% when Native Hawaiian is reported singly. There is also variation among race sub groups an overall estimate of 33.4% of those in the Asian Alone or in combination reporting another race but variation in the 3 largest sub groups range from 42.1% in Filipino to 71.3% 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.

Immigration

Hawaii is considered a gateway to the U.S. for immigrants from Asia and the Pacific. According to the 2015 ACS, 17.7% of Hawaii's population is foreign-born, the 6th highest percentage in the U.S. according to the 2015 ACS estimates. 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 immigrant in Hawaii range from six to nine thousand.

Languages Spoken

Because of this 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 2011-2015 ACS 5-year estimates, an estimated 25.2% Hawaii resident 5 years and over spoke a language other than English at home, compared to 21.0% nationally. An estimated 12.4% of Hawaii residents reported limited English proficiency (4th highest state ranking), compared to 8.6% nationally. The most common languages spoken at home other than English include Other Pacific Island languages (111,515), Tagalog (58,197), Japanese (45,621), Chinese (32,054), and Spanish (26,779) followed by Korean (18,079) and Vietnamese (8,201). (ACS 2011-2013 estimates)

In School Year 2014-2015, 9.4% (15,340) of the state's public school students were enrolled in English Language Learner Program[1]. 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 stripped 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 2014, the social, health, educational, and welfare system costs attributed to the estimated 14,700 COFA migrants in Hawaii was $163 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[2], [3].

In 2015, the Title V agency served an estimated 8,858 COFA migrants at a cost of $5.4 M. 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

2015, comprise an estimated 7.9% of the state's population (112,705 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 2016 Point in Time homeless study (conducted in January 2016) estimates the total number of homeless individuals statewide at 7,921. The proportion of unsheltered individuals (54.4%) was higher than sheltered individuals (45.6%). The trend of homeless has steadily grown over the past 6 years from 6,188 in 2011. About 42.1% (3,331) of the homeless were part of families, including 24.2% (1,913) under age 18 years, of which 572 were unsheltered. Children, in particular, are affected by homelessness which is linked to both behavioral health problems and negative impacts on educational progress.

Maternal and Child Population

Based on 2011-2015 ACS 5-year estimates, the population of the state of Hawaii increased about 5.0% to 1,428,469 residents compared to 2010 when the population was 1,360,301 with the overall median age changing from 38.6 years in 2010 to 38 years in 2015.

The 2011-2015 estimates show that there were 266,402 women of reproductive age (defined as women 15-44 years old) which represents a small 1.6% increase from the 2010 census data of 262,107. This group represents about 18.9% 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 19,000 births every year in the state over the past 5 years.

The 2011-2015 estimates show that there were 175,787 children 9 years of age or younger in Hawaii, which represents a 2.9% increase from 2010 when there were 170,768. This group represents 12.5% of the state population. There were 164,537 children 10-19 years of age in Hawaii, which represents a 1.8% decrease from 2010 when there were 167,533. This group represents 11.7% of the state population.

Based on the 2009/10 National Survey of Children with Special Health Care Needs (CSHCN), there are an estimated 35,000 CSHCN, representing 12.3% of all children ages 0-17 years old.

Older Population

Hawaii's population, like the U.S., is aging. Based on 2011-2015 ACS 5-year estimates, persons age 65 years and over comprised 15.6% of the population, compared to 13.9% in 2006-2010. Nationwide, this population comprised 14.1% in 2011-2015 compared to 12.7% in 2006-2010.

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) second quarter 2017 outlook shows moderate growth for Hawaii's economy in the coming years. 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-farm payroll jobs and improvement in construction industry[5]. The state real gross domestic product (GDP) grew 2.1% in 2016, and is expected to grow by 2.1% in 2017 and 2.4% in 2018. The per capita real GDP in Hawaii was $49,479 in 2015 (in 2009 dollars), $365 or 0.7% lower than the U.S. average. Hawaii ranked 21st 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 recession with a record 47,000 individuals unemployed. According to the Bureau of Labor Statistics, the annual average unemployment rate in Hawaii was 3.6% in 2015, 1.7% point lower than the U.S. average of 5.3% [6]. Hawaii ranked 6th lowest among the 50 states.

State Budget

According to the State of Hawaii Department of Taxation, the State Council on Revenues lowered its forecast for growth in the State General Fund tax revenue in FY 2017 from 3.0% to 2.5%[7]. The Council also lowered its forecast for growth rates from 5.0% to 4.0% in FY 2018 and from 4.4% to 4.0% in FY 2019. The Council noted that the recent declining trend in General Fund tax revenues resulted from lower than expected collection from the General Excise (GET) and Use Tax, and the Individual Income Tax. They also noted the reduction of higher income tax rates on the top income brackets for individual taxpayers after 2015 from 11% to 8.25%.

Tourism

2016 was another record breaking year for tourism with 8.9 million travelers coming to the islands and visitor expenditures of $15.6 billion. Although vulnerable to changing markets and trends, in 2017, forecasters expect visitor arrivals and visitor expenditures will continue to increase.

Poverty

Based on 2011-2015 ACS 5-year estimates, Hawaii's poverty rate in 2011-2015 was 11.2% (all ages in poverty). This represents an estimated 153,944 individuals living in poverty in the state; over 46,131 or 15.2% 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 9.7%; Maui 11.0%; Kauai 10.7%; and Hawaii 19.5%.

The official poverty rate ranks Hawaii as the 7th lowest in the nation. However, 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 rate (which considers factors such as the cost of living, entitlements) for 2011-2013 for Hawaii was 18.4%, 5th highest in the U.S.

Wages

According to the Bureau of Labor Statistics, average annual wages for employees in Hawaii was $46,919 in 2015, $6,023 or 11.4% lower than the U.S. average of $52,942. Hawaii ranked 25th among the 50 states. Among private sector employees only, the situation is worse. Average annual wages for employees in the private sector was $44,393 in 2015, $8,483 or 15.7% lower than the U.S. average, ranking Hawaii 35th.

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 money.com, "The Best and Worst States to Make a Living 2015," ranked Hawaii as the worst state to make a living. When adjusted for taxes and the cost of living, the study found the buying power for average Hawaii wage

earners was 55 cents to the dollar compared to the national average.

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 2017, the median housing cost for a single-family dwelling on Oahu was $712,500 and for a condominium was $415,500. The median monthly owner mortgage cost in 2015 was $2,248, $771 or 52.2% higher than the U.S. average. Among these homeowners, 30.9% spent *35% or more of their household income*, which was higher than the U.S. average of 22.3% (2015 ACS 1-year estimates). Hawaii ranked the highest in the nation for this indicator. Not surprisingly, the homeownership rate in Hawaii in 2015 was one of the lowest in the U.S. (47th among the 50 states) at 56.6%, which was lower than the U.S. average of 63.0%.

Rental Costs

Even for working families, the high cost of fair market rent is out of reach. Based on 2015 ACS 1-year estimates, estimated 43.4% of Hawaii residents rent in 2015 (compared to 37% nationally). The median monthly gross rent for the renter-occupied units (excluding units not paying rent) in Hawaii in 2015 was $1,500, $541 or 56.4.0% higher than the U.S. average of $959. 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 2015 ACS 1-year estimates, the percentage of multigenerational family households among all family households in Hawaii was 11.3%, which was higher than the U.S. average of 5.8%. 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[8], 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 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 federally-supported state-run marketplace for 2016, and is transitioning again to a fully federally-run exchange for 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.

Under the Medicaid expansion provision of the ACA coverage increase to 138% of FPL. The number of people on the program rose significantly from 292,000 to about 360,000 in 2017. This mirrors the national average of roughly 25% Medicaid coverage of the state population. Under ACA more than 30,000 people have enrolled in

private insurance and about 53,000 people have enrolled in Medicaid.

As the possible repeal of ACA looms, state legislative efforts this year included efforts to integrate some of the more significant pieces of the ACA into the Prepaid Healthcare Act. These initiatives yielded the Governor signing Act 43 in June 2017, which establishes the affordable health insurance working group to address the complexities of the health care system, the related uncertainty over the future of the ACA, and to ensure that certain ACA benefits remain available to Hawaii residents under state law. The working group will address and make recommendations related to:

(1) Minimum standard coverage requirements for individuals;
(2) Essential health care benefits;
(3) Rate setting;
(4) Medicaid expansion;
(5) Financial requirements and financing options; and
(6) Other issues that may arise, pursuant to the discretion of the working group.

The ACA provided state-level and provider organization-level demonstation models around innovation. Currently, over 98 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, 2017, are receiving capitated rates. This new payment model continues to receive mixed reviews from the provider community with pediatricians expressing the most concern. With the annual median capitation at $300.00 per member, physicians are concerned about the equity when an infant in their first year of life will have up to 11 visits with their pediatrician, which previously would have yielded approximately $1,100.00 under the old payment system.

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 March 2017, The Hawaii Medicaid Progam provided coverage to 362,940 individuals with 135,379 of them being children through traditional, SCHIP, and current and former foster care eligibility rules. 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 Healthcar.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. With the effective date of January 1, 2017, providers are now able to provide and bill for telehealth services through Medicaid. This puts Medicaid in alignment with commercial insurance which likewise went into effect this year.

GOVERNMENT

Hawaii's Executive Branch of government is organized into many departments, most of which are grouped 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 elected in 2014 and appointed Dr. Virginia "Ginny" Pressler, M.D. as Director of Health and the former Title V Director and FHSD Chief, Danette Wong Tomiyasu as the DOH Deputy Director for HRA. In 2016, Dr. Matthew Shim was hired to fill the vacant FHSD Chief/Title V Director position.

STATE DEPARTMENT OF HEALTH: CURRENT PRIORITIES & INITIATIVES

In 2016, a new DOH strategic plan was completed. The Strategic Map: 2015 – 2018 focuses on "Health in All Policies" as an approach to address the social determinants of health that are key drivers of health outcomes and health inequities. This new plan depicts the challenge of the Department to "Make Health Hawaii's Shared Value" which will:

- Address the Social Determinants of Health;

- Assure a Health Perspective in All Public Policies; and,
- Use Evidence-Based Practices and Make Data-Driven Decisions.

The three strategic plan priorities which frame the work for DOH 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 the strategies and activities in Title V Maternal and Child Health 5-Year Plan fall into the Strategic Priority A: Invest in Healthy Babies and Families. This synergy allows for greater collaboration and focused concentration on the broader maternal and child health priorities.

Title V Domains	DOH Strategic Plan	Title V Priorities
Women's/Maternal Health	Reduce substance use and exposure for expectant mothers	Promote Screening, Brief Intervention, and Referral to Treatment (SBIRT) for expecting mothers.
Women's/Maternal Health	Decrease unintended pregnancies	Promote reproductive life planning
Perinatal/Infant Health	Improve post-partum care for moms, dads and baby	Reduce the rate of hospitalization to non-fatal injuries among children 0-9 years and adolescents 10-19 years
Perinatal/Infant Health	Increase rates of breastfeeding	Reduce the rate of infant mortality by improving breastfeeding rates
Child Health	Assure access to universal health and developmental screenings	Improve the percentage of children screened early and continuously age 0-5 years for developmental delay
Child Health	Better understand conditions contributing to child deaths and maternal mortality	Reduce the rate of infant mortality
Children with Special Health Care Needs	Improve life prospects for vulnerable and disabled persons	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
Adolescent Wellness	Plan for a system of care for adolescents that addresses physical and emotional health	Improve the healthy development, health, safety, and well-being of adolescents
Cross-Cutting	Maximize adoption of telehealth as a community standard of care	Improve access to services through telehealth

[1] Total number of public school students is found on Hawaii State Department of Education school enrollment counts. Number of English Language Learner is found on page 48 of the Consolidated State Performance Report for school year 2014-15 https://www2.ed.gov/admins/lead/account/consolidated/sy14-15part1/hi.pdf

[2] COFA reports are found on https://www.doi.gov/oia/reports/Compact-Impact-Reports . The latest available update is 2014.

[3] COFA reports are found on https://www.doi.gov/oia/reports/Compact-Impact-Reports . The latest available update is 2014.

[4] Number of armed forces residents and military dependents is found on http://dbedt.hawaii.gov/economic/databook/2015-individual/_01/

[5] Based on the report on Hawaii's economy http://dbedt.hawaii.gov/blog/17-28/

[6] 2015 unemployment rate is found on https://www.bls.gov/lau/lastrk15.htm

[7] Based on the general fund forecast on March 13,2017, http://tax.hawaii.gov/useful/a9_1cor/

[8] 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/

II.B. Five Year Needs Assessment Summary and Updates

FY 2018 Application/FY 2016 Annual Report Update

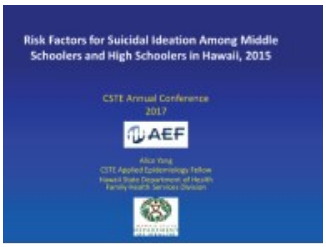
II.B.1. PROCESS

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.

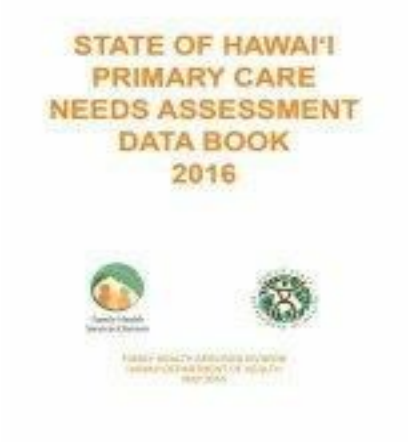
The **Early Language Working Group** (ELWG) was established by Act 177 of the 2016 State Legislature. The purpose of the ELWG is to make recommendations to the legislature on issues related to supporting age-appropriate language development for children age 0-5 years who are deaf, hard of hearing, or 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.

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.

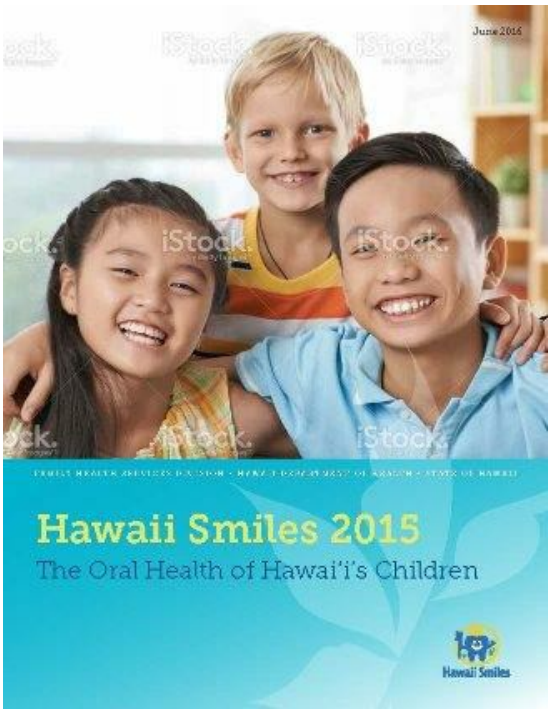
Publications in peer-review journals included: underdiagnosis of conditions associated with sudden cardiac death in children; depression, anxiety, and pharmacotherapy around the time of pregnancy; and predictors of dental cleaning over a two-year time period around pregnancy among Asian and Native Hawaiian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

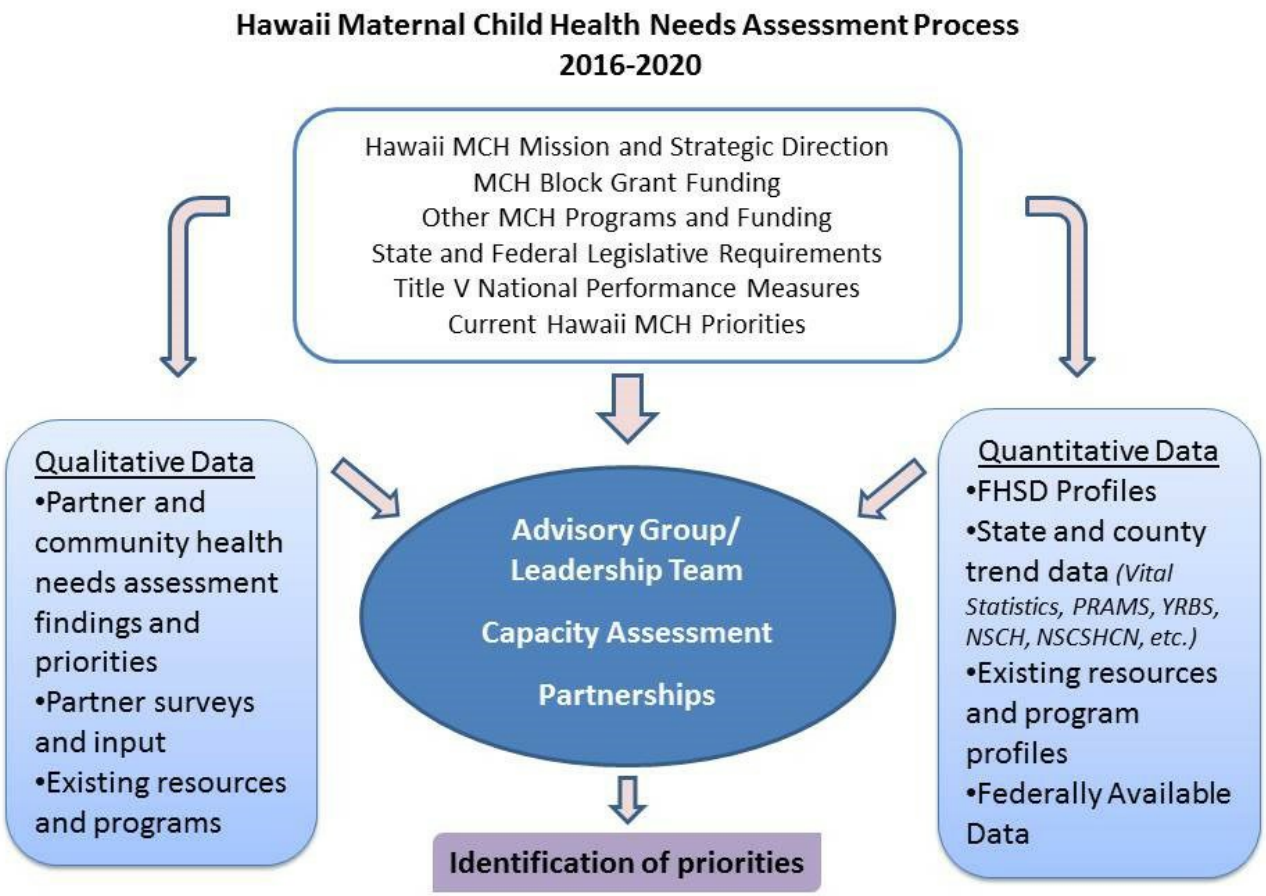
The needs assessment framework included:

- 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).

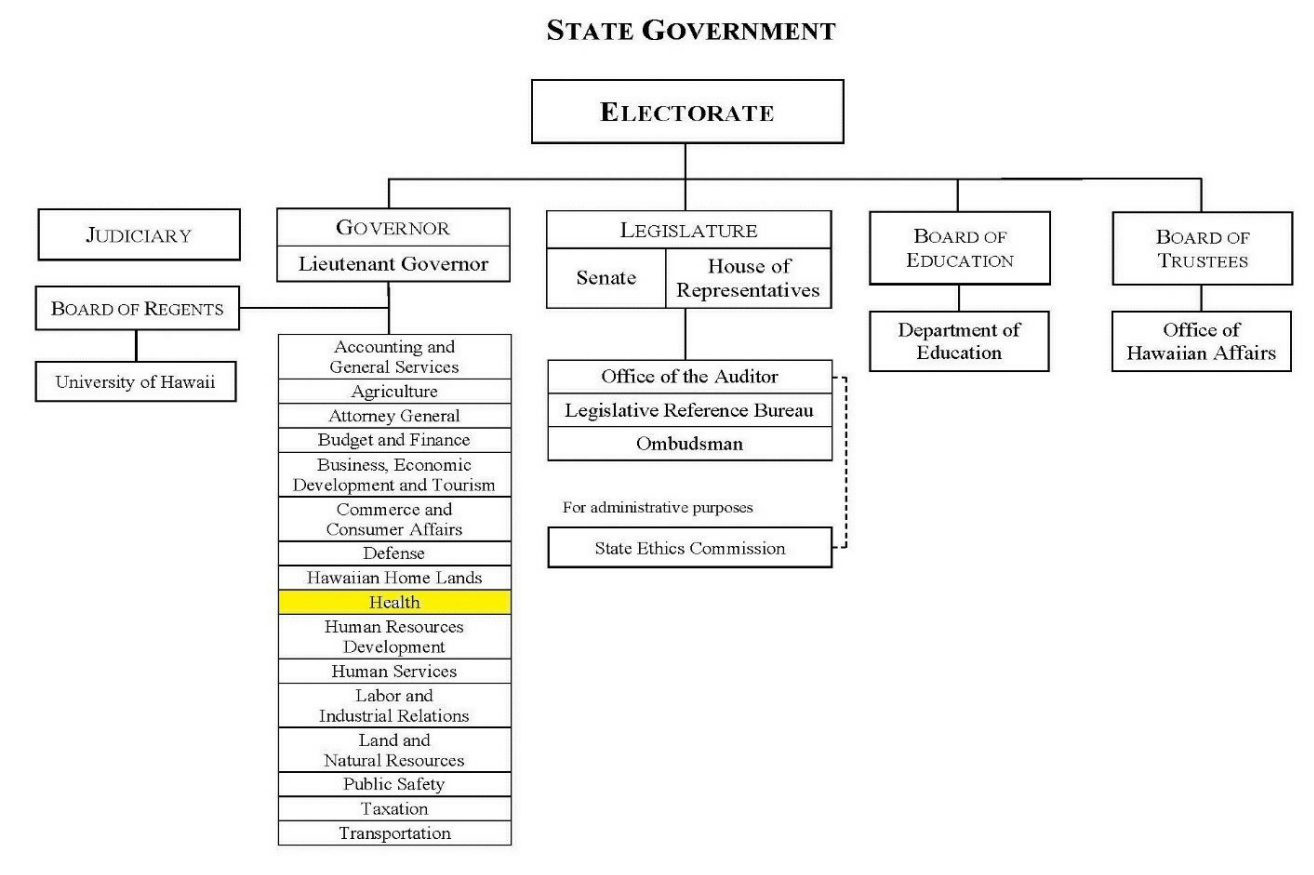


Figure 1

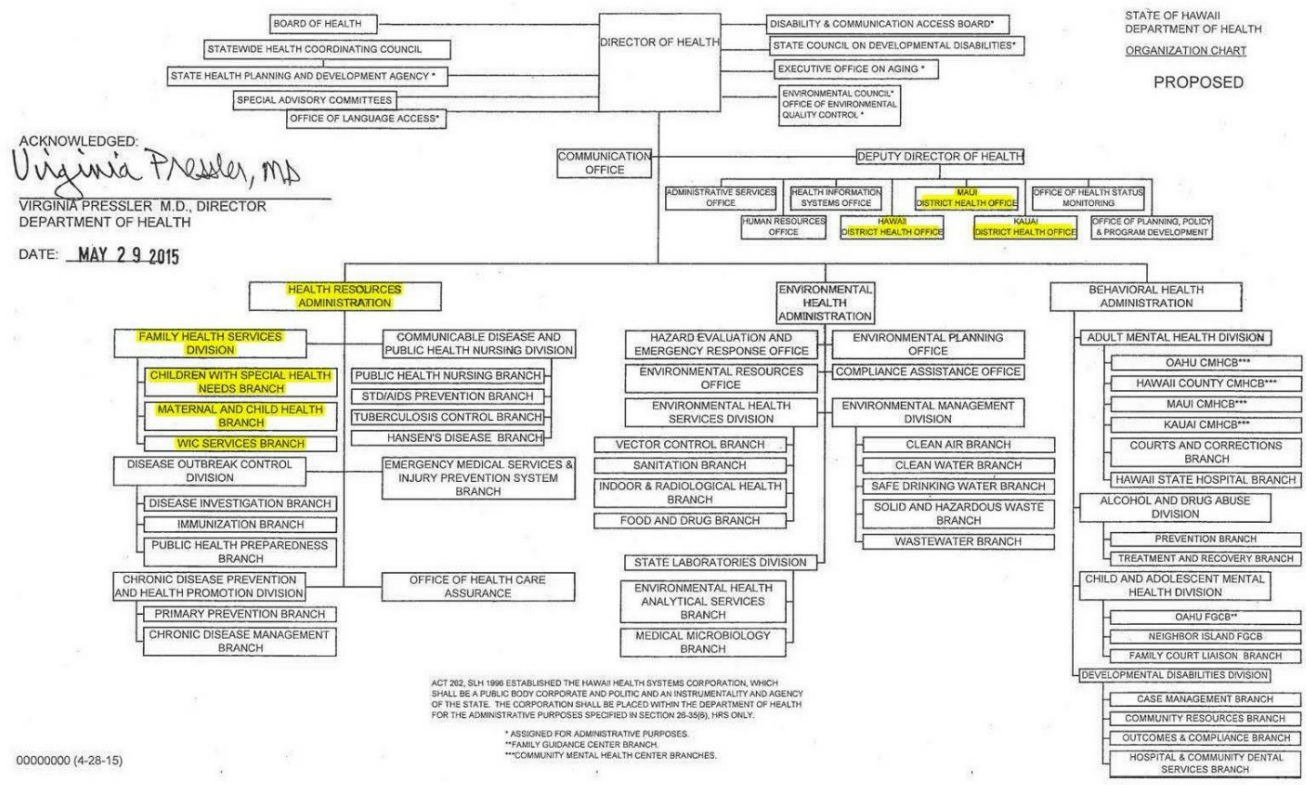

STATE OF HAWAII
DEPARTMENT OF HEALTH
ORGANIZATION CHART
PROPOSED
BOARD OF HEALTH
STATEWIDE HEALTH COORDINATING COUNCIL
STATE HEALTH PLANNING AND DEVELOPMENT AGENCY *
SPECIAL ADVISORY COMMITTEES
OFFICE OF LANGUAGE ACCESS*
DIRECTOR OF HEALTH
DISABILITY & COMMUNICATION ACCESS BOARD*
STATE COUNCIL ON DEVELOPMENTAL DISABILITIES*
EXECUTIVE OFFICE ON AGING *
ENVIRONMENTAL COUNCIL* OFFICE OF ENVIRONMENTAL QUALITY CONTROL *
ACKNOWLEDGED:
Virginia Pressler, MD
VIRGINIA PRESSLER M.D., DIRECTOR
DEPARTMENT OF HEALTH
DATE: MAY 29 2015
COMMUNICATION OFFICE
DEPUTY DIRECTOR OF HEALTH
ADMINISTRATIVE SERVICES OFFICE
HEALTH INFORMATION SYSTEMS OFFICE
MAUI DISTRICT HEALTH OFFICE
OFFICE OF HEALTH STATUS MONITORING
HUMAN RESOURCES OFFICE
HAWAII DISTRICT HEALTH OFFICE
KAUAI DISTRICT HEALTH OFFICE
OFFICE OF PLANNING, POLICY & PROGRAM DEVELOPMENT
HEALTH RESOURCES ADMINISTRATION
FAMILY HEALTH SERVICES DIVISION
CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH
MATERNAL AND CHILD HEALTH BRANCH
WIC SERVICES BRANCH
DISEASE OUTBREAK CONTROL DIVISION
DISEASE INVESTIGATION BRANCH
IMMUNIZATION BRANCH
PUBLIC HEALTH PREPAREDNESS BRANCH
CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION DIVISION
PRIMARY PREVENTION BRANCH
CHRONIC DISEASE MANAGEMENT BRANCH
COMMUNICABLE DISEASE AND PUBLIC HEALTH NURSING DIVISION
PUBLIC HEALTH NURSING BRANCH
STD/AIDS PREVENTION BRANCH
TUBERCULOSIS CONTROL BRANCH
HANSEN'S DISEASE BRANCH
EMERGENCY MEDICAL SERVICES & INJURY PREVENTION SYSTEM BRANCH
OFFICE OF HEALTH CARE ASSURANCE
ENVIRONMENTAL HEALTH ADMINISTRATION
HAZARD EVALUATION AND EMERGENCY RESPONSE OFFICE
ENVIRONMENTAL RESOURCES OFFICE
ENVIRONMENTAL HEALTH SERVICES DIVISION
VECTOR CONTROL BRANCH
SANITATION BRANCH
INDOOR & RADIOLOGICAL HEALTH BRANCH
FOOD AND DRUG BRANCH
STATE LABORATORIES DIVISION
ENVIRONMENTAL HEALTH ANALYTICAL SERVICES BRANCH
MEDICAL MICROBIOLOGY BRANCH
ENVIRONMENTAL PLANNING OFFICE
COMPLIANCE ASSISTANCE OFFICE
ENVIRONMENTAL MANAGEMENT DIVISION
CLEAN AIR BRANCH
CLEAN WATER BRANCH
SAFE DRINKING WATER BRANCH
SOLID AND HAZARDOUS WASTE BRANCH
WASTEWATER BRANCH
BEHAVIORAL HEALTH ADMINISTRATION
ADULT MENTAL HEALTH DIVISION
OAHU CMHCB***
HAWAII COUNTY CMHCB***
MAUI CMHCB***
KAUAI CMHCB***
COURTS AND CORRECTIONS BRANCH
HAWAII STATE HOSPITAL BRANCH
ALCOHOL AND DRUG ABUSE DIVISION
PREVENTION BRANCH
TREATMENT AND RECOVERY BRANCH
CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
OAHU FGCB**
NEIGHBOR ISLAND FGCB
FAMILY COURT LIAISON BRANCH
DEVELOPMENTAL DISABILITIES DIVISION
CASE MANAGEMENT BRANCH
COMMUNITY RESOURCES BRANCH
OUTCOMES & COMPLIANCE BRANCH
HOSPITAL & COMMUNITY DENTAL SERVICES BRANCH
ACT 202, SLH 1996 ESTABLISHED THE HAWAII HEALTH SYSTEMS CORPORATION, WHICH SHALL BE A PUBLIC BODY CORPORATE AND POLITIC AND AN INSTRUMENTALITY AND AGENCY OF THE STATE. THE CORPORATION SHALL BE PLACED WITHIN THE DEPARTMENT OF HEALTH FOR THE ADMINISTRATIVE PURPOSES SPECIFIED IN SECTION 26-35(6), HRS ONLY.
* ASSIGNED FOR ADMINISTRATIVE PURPOSES.
**FAMILY GUIDANCE CENTER BRANCH.
***COMMUNITY MENTAL HEALTH CENTER BRANCHES.
00000000 (4-28-15)

Figure 2

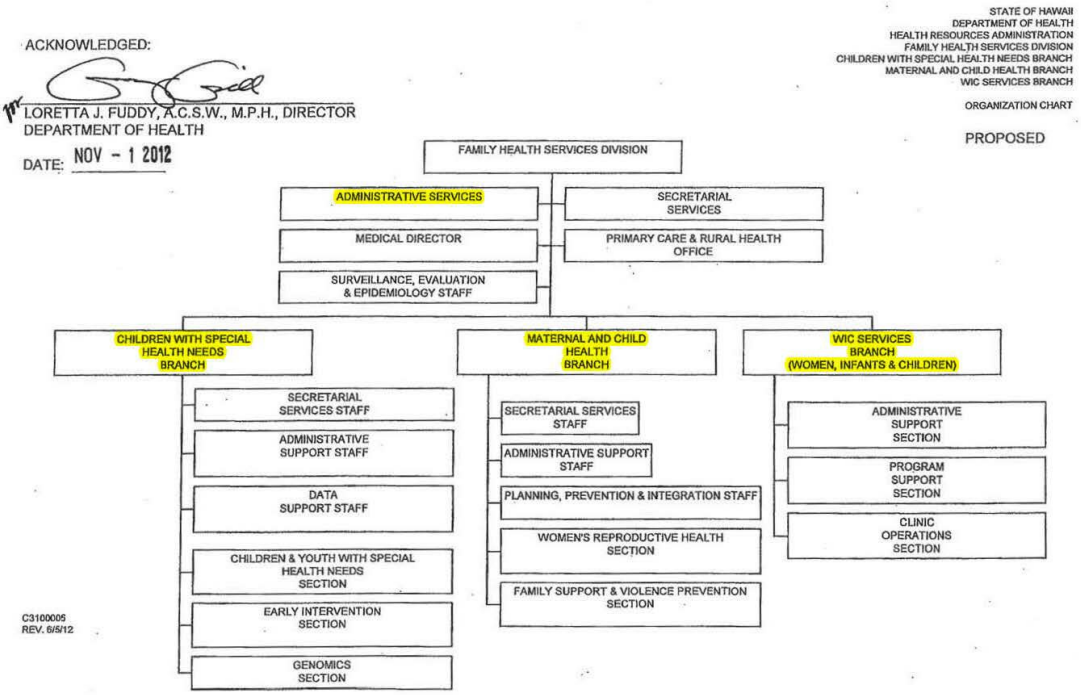

STATE OF HAWAII
DEPARTMENT OF HEALTH
HEALTH RESOURCES ADMINISTRATION
FAMILY HEALTH SERVICES DIVISION
CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH
MATERNAL AND CHILD HEALTH BRANCH
WIC SERVICES BRANCH
ORGANIZATION CHART
PROPOSED
ACKNOWLEDGED:
LORETTA J. FUDDY, A.C.S.W., M.P.H., DIRECTOR
DEPARTMENT OF HEALTH
DATE: NOV - 1 2012
FAMILY HEALTH SERVICES DIVISION
ADMINISTRATIVE SERVICES
SECRETARIAL SERVICES
MEDICAL DIRECTOR
PRIMARY CARE & RURAL HEALTH OFFICE
SURVEILLANCE, EVALUATION & EPIDEMIOLOGY STAFF
CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH
SECRETARIAL SERVICES STAFF
ADMINISTRATIVE SUPPORT STAFF
DATA SUPPORT STAFF
CHILDREN & YOUTH WITH SPECIAL HEALTH NEEDS SECTION
EARLY INTERVENTION SECTION
GENOMICS SECTION
MATERNAL AND CHILD HEALTH BRANCH
SECRETARIAL SERVICES STAFF
ADMINISTRATIVE SUPPORT STAFF
PLANNING, PREVENTION & INTEGRATION STAFF
WOMEN'S REPRODUCTIVE HEALTH SECTION
FAMILY SUPPORT & VIOLENCE PREVENTION SECTION
WIC SERVICES BRANCH (WOMEN, INFANTS & CHILDREN)
ADMINISTRATIVE SUPPORT SECTION
PROGRAM SUPPORT SECTION
CLINIC OPERATIONS SECTION
C3100005
REV. 6/5/12

Figure 3

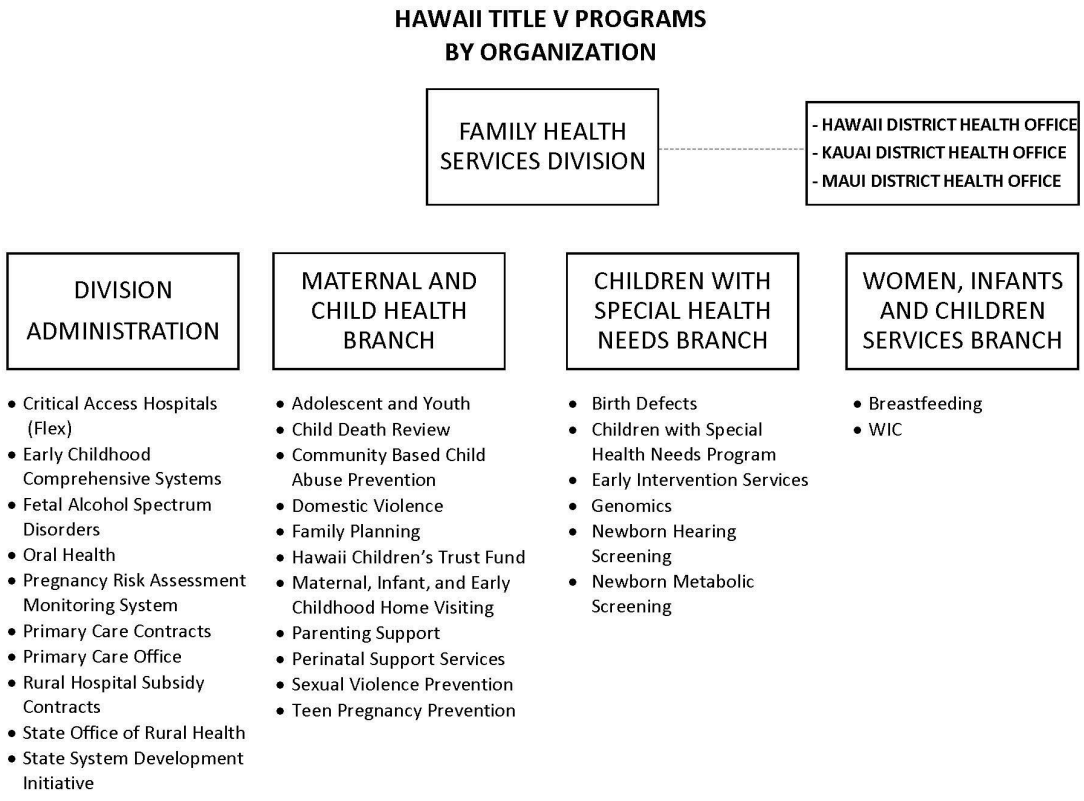


Figure 3.a.

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

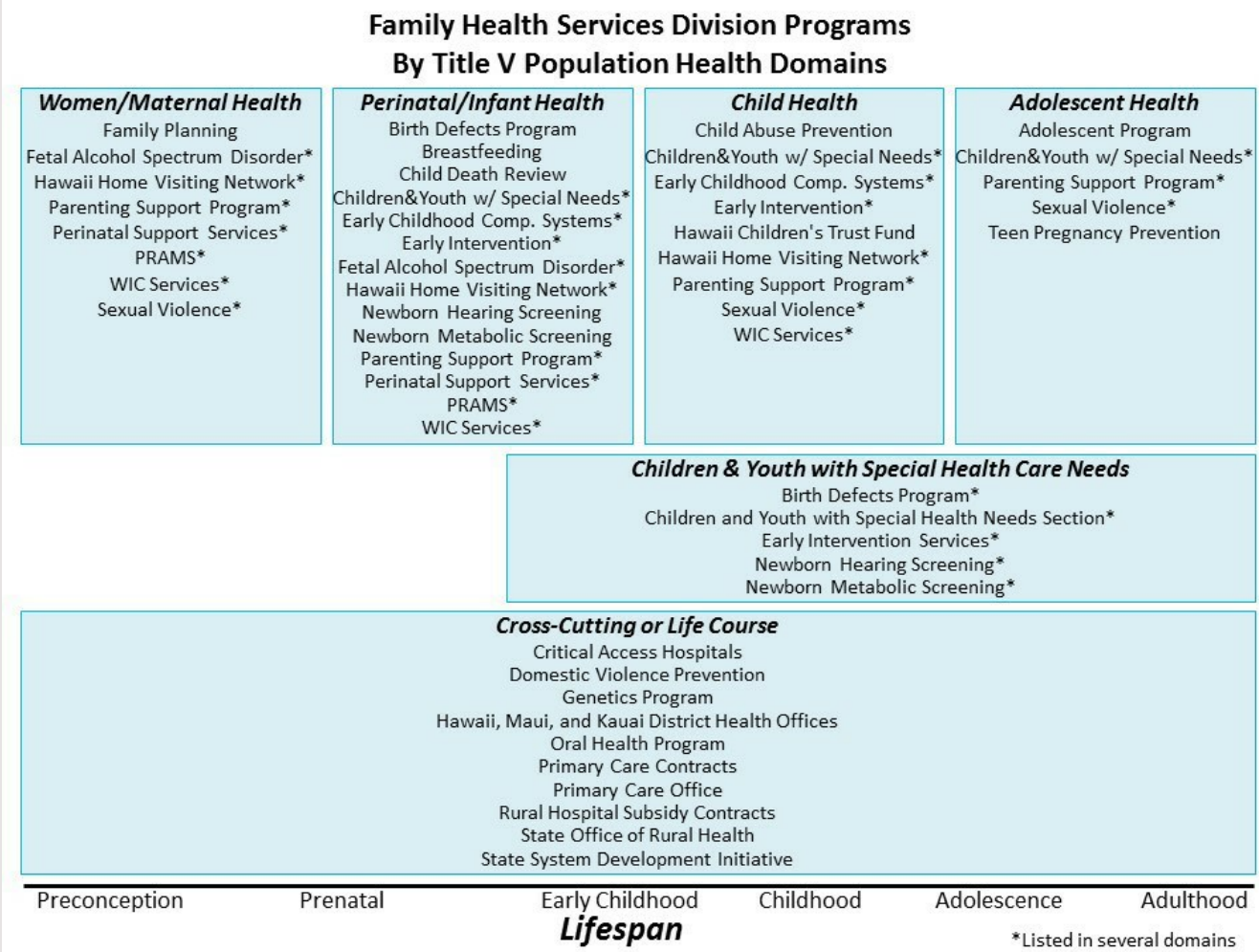
STATE'S CAPACITY TO PROMOTE AND PROTECT THE HEALTH OF MOTHERS AND CHILDREN, INCLUDING CSHCN

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).



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.

II.C. State Selected Priorities

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 and pregnant women.
7	Improve the healthy development, health, safety, and well-being of adolescents
8	Improve access to services through telehealth
9	Improve family and consumer engagement in Title V Programs.
10	Improve partner engagement in Family Health Services Division (FHSD).

For FY 2016-2020, the Hawaii Title V program selected the following 10 priority needs based on the findings of the Five-Year Needs Assessment.

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 and promoting safe sleep practices
Child Health	Improve the percentage of children age 0-5 years screened early and continuously for developmental delay
	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 14-21 years who receive services necessary to make transitions to adult health care
Cross-Cutting or Life Course	Improve the oral health of children and pregnant women
	Improve access to services through telehealth
	Improve family and consumer engagement in Title V programs (NEW in 2016)
	Improve meaningful partnerships with FHSD (NEW in 2016)

How Priority Needs were Determined

FHSD conducted the 2015 needs assessment cognizant of strategically leveraging existing resources; building upon established collaborative initiatives; capitalizing on partnerships; and developing capacity by building on current programs, initiatives and strategies. Using this approach FHSD was able to reduce duplication of assessment efforts on a small state population, and assure Title V priorities and plans were well-aligned with key partners in public health and the health care system.

Hawaii analyzed results from recent needs assessments to assure the information was current and stakeholders would not repeat their concerns. In addition, plans, priorities, position statements, and other documents of various state/community agencies and organizations were examined to identify their MCH issues. The 2015 Title V needs assessment has the complete list of needs that were considered

To determine which priority measures would be most meaningful to the state, these selection criteria were used:

1. Data reflect a need and opportunity for improvement.
2. FHSD could take a lead or major role for the issue.
3. FHSD has capacity and resources (staffing and funding) to address the issue.
4. An expressed interest or concern raised by the community and an opportunity to align efforts with existing groups.

Change in State Priority Needs

Priority Needs 2011-2015	Priority Needs 2016-2020	Comment
Reduce the rate of unintended pregnancy	Promote reproductive life planning **CONTINUED**	Renamed/expanded broader approach, including also promoting preconception health care visits and healthy behaviors.
Reduce the rate of alcohol use during pregnancy REPLACED		FHSD no longer has a Fetal Alcohol Spectrum Disorder (FASD) Coordinator position. Work on this area continues with the Hawaii Maternal and Infant Health Collaborative.
	Reduce the rate of infant mortality by improving breastfeeding rates and promoting safe sleep practices. **NEW in 2015**	Need identified through Title V needs assessment
Reduce the rate of overweight and obesity in young children ages 0-5 REPLACED		FHSD does not have a lead role. DOH Chronic Disease Prevention and Health Promotion Division is the DOH lead for Physical Activity and Nutrition.
Improve the percentage of children age 0-5 years screened early and continuously for developmental delay	Improve the percentage of children age 0-5 years screened early and continuously for developmental delay **CONTINUED**	While rates are high, there is still a continued need for improvement
Reduce the rate of child abuse and neglect with special attention on ages 0-5 years	Reduce the rate of child abuse and neglect with special attention on ages 0-5 years **CONTINUED**	Data indicate need for improvement
	Improve the healthy development, health, safety, and well-being of adolescents **NEW in 2015**	Need identified through Title V needs assessment
Improve the percentage of youth with special health care needs age 14-21 years who receive services necessary to make transitions to adult health care	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**	Data indicate need for improvement
Improve the oral health of children age 0-18 years	Improve the oral health of children and pregnant women **CONTINUED**	Pregnant women were added to be more aligned with the National Performance Measure
	Improve access to services through telehealth **NEW in 2015**	Need identified through Title V needs assessment
	Improve family and consumer engagement in Title V programs **NEW in 2016**	Need identified through Title V needs assessment
	Improve meaningful partnerships with FHSD **NEW in 2016**	Need identified through Title V needs assessment

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 1 - Percent of women with a past year preventive medical visit
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 5 - Percent of infants placed to sleep on their backs
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
- NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
- NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Domain	State Priority	Related National Performance Measure (NPM)	Rationale for Selection of NPM
Women's/ Maternal Health	Promote reproductive life planning	NPM 1 – Percent of women with a past year preventive medical visit	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.
Perinatal/ Infant Health	Reduce the rate of infant mortality by improving breastfeeding rates and promoting safe sleep practices	NPM 4 – A) Percent of infants who are ever breastfed. B) Percent of infants breastfed exclusively through 6 months.	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.
		NPM 5 – Percent of infants placed to sleep on their backs.	Sleep-related deaths are the leading cause of infant death after the first month of life and the third leading cause of infant death overall.
Child Health	Promote early childhood screening and development	NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool.	Screening is important for the early identification of developmental concerns and appropriate follow-up, including referrals to early intervention or special education services.
	Prevent child abuse and neglect	NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children age 0 through 9 and adolescents age 10 through 19.	Injuries are the leading cause of death among children. Non-fatal injuries due to child abuse and neglect may result in hospitalization.
Adolescent Health	Promote adolescent well-being	NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	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.
Children with Special Health Care Needs	Promote transition to adult health care	NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions 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.
Cross-Cutting or Life Course	Improve oral health	NPM 13 – A) Percent of women who had a dental visit during pregnancy. B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.	Access to oral health care is essential to reduce the risk of 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.

Each of the above state priorities is linked with a National Performance Measure and National Outcome Measures in the Five-Year State Action Plan. There are no changes to the selected National Performance Measures.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

- SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers.
- SPM 2 - The percentage of Family Health Services Division (FHSD) staff that have increased their knowledge on family/consumer engagement.
- SPM 3 - The percentage of Family Health Services Division (FHSD) staff that have increased their knowledge on Partner Engagement.

Domain	State Priority	Related State Performance Measure (SPM)	Rationale for Selection of SPM
Cross-Cutting or Life Course	Improve access to services through telehealth	Degree to which Title V programs utilize telehealth to improve access to services and education for families and providers.	With personnel reductions, increased travel costs, and availability of high speed internet and affordable devices, telehealth can increase access to services and education while saving costs and travel time. Telehealth can increase access to services for families, care coordination, education for providers, and public health workforce training. Within FHSD, there is support for efforts to implement or increase telehealth activities for genetics, newborn screening, early intervention, and home visiting.
	Improve family and consumer engagement in Title V programs	Increase the engagement of families and consumers in Family Health Services Division activities	Having families/consumers engaged with Title V Programs helps to increase optimal health outcomes for children and families, through increased awareness of family needs, increased parent/professional communication, and improved policies and responsiveness to family needs. Family/consumer engagement in policy and advocacy, program improvement, and public awareness can lead to improving outcomes for Title V programs and children/families.
	Improve meaningful partnerships with FHSD	Increase meaningful partnerships with Family Health Services Division Programs	In the 2010 FHSD strategic planning, FHSD determined that its primary audience was not families, but instead partners, stakeholders, and contractors. The Title V needs assessment was a step in recognizing that many partners are working on similar issues and doing needs assessments. FHSD recognizes the importance of partnerships for improved health outcomes for children and

The state selected priorities are linked to the SPM in the Five-Year State Action Plan. These priorities will impact the FHSD work on the ESMs for the state priorities linked to the NPM and NOMs.

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

The plan narratives for application Year 2018 address the new National Performance Measures (NPM) by population domain as reflected in the 5-year plan. Hawaii is using the plan template provided in the Title V guidance. The Plan narratives are organized as follows:

- Review the information found in the plan table template;
- Report on Plans for FFY 2018;
- Report on FFY 2016 and FFY 2017 current activities for the Strategy Measures (ESM) as well as other 5-year strategies;
- Discussion National Performance Measure (NPM) and National Outcome Measure (NOM) data.

Three state performance measures (SPM) were identified through the 5-year needs assessment and are included in the Cross-Cutting domain.

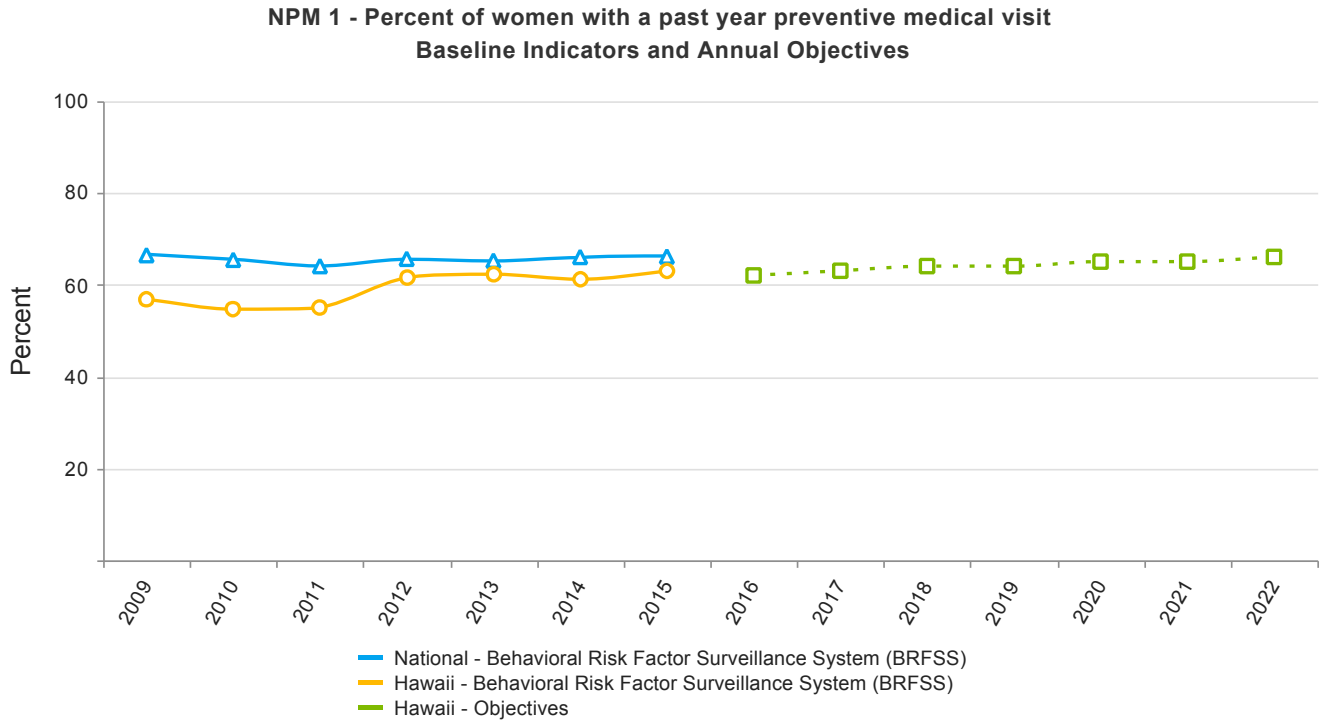
Work plans were developed for next 2 year period and assumed current state and federal funding levels over the next two years.

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-2014	159.5	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available	NPM 1
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	8.3 %	NPM 1
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.3 %	NPM 1
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	7.0 %	NPM 1
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	10.1 %	NPM 1
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.7 %	NPM 1
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	7.4 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	27.9 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	5.0	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	4.5	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	3.3	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.1	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	177.9	NPM 1

National Performance Measures



Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	62
Annual Indicator	63.0
Numerator	152,559
Denominator	242,088
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	63.0	64.0	64.0	65.0	65.0	66.0

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
Annual Objective	
Annual Indicator	33.5
Numerator	3,219
Denominator	9,616
Data Source	vital statistics
Data Source Year	2015
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	34.0	34.0	35.0	35.0	35.0	35.0

State Action Plan Table

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

Priority Need

Promote reproductive life planning

NPM

Percent of women with a past year preventive medical visit

Objectives

By July 2020, increase the percent of women with a preventive medical visit in the last year to 65% (Baseline: 2013 BRFSS data 62.3%)

Strategies

Promote preconception health care visits (e.g. identify access barriers, community and provider education, public awareness)

Promote reproductive life planning (e.g. increase birth spacing, improve access to family planning)

Promote healthy behaviors (e.g. smoking cessation, decrease alcohol and substance use, maintain healthy weight, use of folic acid, chronic disease control)

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

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 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

Women/Maternal Health - Plan for the Application Year

Priority Need: Women's Preventive Medical Visit

The 5-year needs assessment affirmed the importance of women's preventive health care as a priority issue based on the work of:

- Executive Office of Early Learning Action Strategy Planning (specifically the component focused on "Healthy and Welcomed Births",
- 2013 National Governor's Association (NGA) Learning Network to improve Birth Outcomes,
- Establishment of the Hawaii Maternal and Infant Health Collaborative (HMIHC) to improve birth outcomes and reduce infant mortality, and
- Hawaii participation in the national Infant Mortality Collaborative Improvement and Innovation Network (CoIIN).

The Title V agency received the NGA Learning Network technical assistance (TA) award to improve Birth Outcomes. The application was developed in conjunction with the March of Dimes Hawaii Chapter. The Hawaii team participated in the 2013 Learning Network Conference on Improving Birth Outcomes held in Washington, D.C. to assist states in developing, implementing and aligning their key policies and initiatives related to the improvement of birth outcomes. This TA supported a series of planning sessions in 2013 with a broad group of stakeholders to develop a comprehensive approach to improve birth outcomes in Hawaii. This effort was conducted in partnership with the Executive Office of Early Learning (EOEL) Action Strategy initiative which included a workgroup on "Healthy and Welcomed Births."

The Hawaii Maternal and Infant Health Collaborative (HMIHC) was formed to sustain the planning and implementation work begun through the NGA TA. The HMIHC completed a strategic plan and Logic Model, *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 the HMIHC including physicians, clinicians, public health professionals, providers, insurance representatives and health care administrators.

Women's preventive health is viewed as a critical factor to reduce infant mortality and improve birth outcomes. Thus, the HMIHC has a work group focused on preconception and interconception care which addresses the preventive health needs of reproductive age women. The HMIHC goals for preconception and interconception care are to reduce unintended pregnancy and improve birth spacing through reproductive life planning education and counseling.

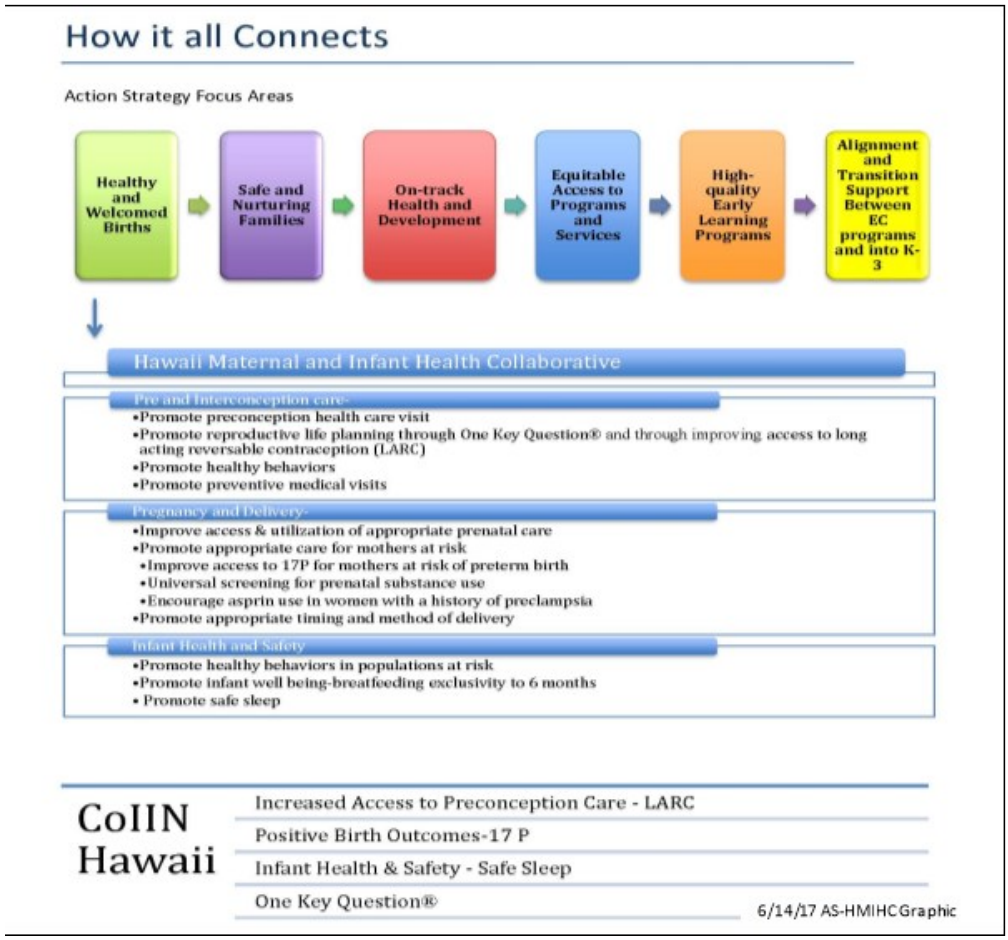
Subsequently, the State participated in several national Infant Mortality Collaborative Information and Innovative Network (CoIIN) meetings and utilized the strategic goals set by the HMIHC to select CoIIN projects for Hawaii. Hawaii has also drawn from the HMIHC to provide leadership and direction for CoIIN projects. Each CoIIN project has a Department of Health (DOH) and community partner as co-leaders.

Two evidence based/informed strategies were selected from the CoIIN targeting women of reproductive age: 1) Long Acting Reversible Contraception (LARC), 2) One Key Question® (OKQ®) pregnancy intention screening tool for use in routine and preventive settings to assure women are directed to appropriate reproductive health services. The OKQ® Algorithm also supports discussions and interventions that can prevent a number of health issues for women. The Oregon Foundation for Reproductive Health (OFRH) is the proprietor of OKQ® which is a registered trademark.

Reducing unintended pregnancy was a Title V priority from the previous 5-year project period and still considered important by the HMIHC. Expanding the focus on women's preventive health overall was initially a new Title V priority

for Hawaii. However, since it was selected as a priority, the HMIHC have generally supported integration of this goal.

The schematic below shows how the women's health Title V priority strategies/activities are integrated into the HMIHC, CoIIN, and EOEL efforts through the Action Strategies.



Family Health Services Division (FHSD), the Title V agency, recognizes the importance of women's health. FHSD's Maternal and Child Health Branch (MCHB) has a "Women's and Reproductive Health Section" that includes programs for Adolescent health, Perinatal health and the federal Title X Family Planning services grant. Grouping the programs together allows the Section to maximize its limited staff and funding by increasing collaboration among the existing programs and improving partnerships with community based organizations.

In addition, the DOH Strategic Plan 2015-2018 has made OKQ® a priority to decrease unplanned pregnancies. If pregnancy is not a woman's choice, then service options should be made available including highly effective forms of contraception such as LARC to support the individuals' health goals.

National Performance Measure 12:

Percent of women ages 18 through 44 with preventive medical visit in the past year.

The state priority is based on the Title V block grant guidance National Performance Measures (NPM) for women's health. The HMIHC identified several objectives relating to women's preconception and interconception health which do not include the Title V NPM for women's health. Discussions were conducted with the Title V

women's health program staff, the CoIIN project team, and HMIHC leadership group to determine the best alignment with the HMIHC plan, Hawaii CoIIN projects, and Title V women's health program resources. The consensus was to select the Title V NPM to increase preventive medical visits and develop a preliminary objective around the NPM. Discussions have continued to address the formal integration of the Title V measure into the existing HMIHC strategic plan and logic model.

Objective

By July 2020, increase the percentage of women ages 18 through 44 with a preventive medical visit in the past year to 65% (Baseline: 2014 BRFSS data 61.1%)

5-Year Strategies

- Promote preconception health care visit (e.g. identify access barriers, community and provider education, public awareness)
- Promote reproductive life planning (e.g. increase birth spacing, improve access to family planning services)
- Promote healthy behaviors (e.g. smoking cessation, decrease alcohol and substance use, maintain healthy weight, use of folic acid, chronic disease control)

Strategy Development

These strategies are taken from the HMIHC pre-interconception work group objectives and its plan to increase access to LARC and promotion of OKQ® in settings where reproductive age women are likely to be screened every three months to a year. Implementation activities have been developed in partnership with HMIHC members including March of Dimes Hawaii Chapter, Medicaid, Governor's Office on Health Care Transformation, Hawaii American Congress of Obstetricians and Gynecologists, Hawaii Section (Hawaii ACOG), and the University of Hawaii John A Burns School of Medicine (JABSOM).

Evidence Based/ Informed Strategy Measures

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 the HIMHC goals for preconception and interconception care (women's preventive health) to improve birth spacing through reproductive life planning education and counseling.

The measure uses vital statistics data from birth certificates with valid clinical estimates of gestational age of index birth and prior live birth. Objectives for the ESM were set to achieve a 5% improvement by 2020 and was based on 2014 data of 29.9% of births had pregnancy interval of < 18 months. Data will be update annually by the FHSD research statistician and reviewed by the epidemiologist. See Form 10C for the Detail Sheet.

Plans for Application Year Federal Fiscal Year 2018 (10/1/17-9/30/18)

The Title V ESM 1.1 project work plan can be found in Section V Supporting documents. The work plan includes some of the following activities:

- Continue work with the HMIHC, which includes Med-QUEST representation, on implementation of Medicaid policy on LARC reimbursement and distribute LARC updated chart of coverage and coding for clinicians.
- 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
- Continue to encourage hospital in-patient pharmacy LARC stocking
- Assess if barriers have been reduced (e.g. availability of pharmacy stock for hospital in-patients)
- Continue to conduct clinical and non-clinical OKQ® implementation training
- Continue to implement OKQ® plan (e.g. assessment)

- Conduct contraceptive training for non-clinical staff implementing OKQ®.

Based on the success of trainings, both clinical and non-clinical OKQ® provider trainings will be ongoing. A second video module will be developed on basic contraceptive information for non-clinical providers. Discussions are also occurring with the DOH, FHSD, Genomics Section to implement OKQ® trainings through telehealth.

Over 20,000 OKQ® brochures will be printed and distributed for use by providers. The brochures display logos for both the Department of Health and the Department of Human Services, which administers the Medicaid program. In 2017, the OKQ® brochure will be translated into Chuukese, Marshallese, Pohnpeian, Illocano, Tagalog, Vietnamese and Mandarin. A copy of the brochure is in Section V Supporting Documents.

The 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 forming plans 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. The pre-interconception work group will focus on public awareness and clarifying messaging to promote healthy behaviors that support women's health and preventive wellness visits including reproductive life planning.

Report on Federal Fiscal Year 2016 (10/1/15 – 9/30/16)

The FFY 2016 ESM indicator is birth spacing of <18 months among those with at least one prior pregnancy was 33.5%. Many planning activities occurred during FFY 2016 to impact the measure focusing on the two evidence based activities – promotion of LARC and OKQ®. Discussions also continued on integration of the Title V measure into existing HMIHC and CoIIN work.

HMIHC/Title V Alignment

The HMIHC goals for women's preventive health are to reduce unintended pregnancy and improve birth spacing through reproductive life planning and counseling. This aligns with the Title V priority need to promote reproductive life planning and increase preventive medical visits in the past year. The HMIHC pre-interconception work group developed a logic model for its work. Components of the logic model informed the Title V strategy and ESM selection for this NPM.

Title V staff shared the 5-year plan template at the Association of Maternal and Child Health Programs (AMCHP) Technical Assistance session in April 2016. Staff found the sharing of information between states helpful in drafting ESM.

At the August 2016 in-state Title V grant review, the NPM 1 women's health ESM received general approval. However, a suggestion was made to clearly state the challenge Hawaii faced aligning the Title V women's health domain measures with the existing state plans addressing women's reproductive health. The narrative this year has been revised accordingly.

LARC

Work was started in 2015 to increase access to LARC. One of the major 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 2015, two white papers were developed by the HMIHC and were distributed to increase awareness for the need of insurance reimbursement for post-pregnancy LARC. A chart with reimbursement codes for LARC was later developed and distributed by HMIHC and through provider partnerships such as Hawaii ACOG. In 2015 the MCHB through the Reproductive Health Services Unit held a reproductive health training for providers on LARC.

Medicaid reimbursement for LARC use postpartum required additional work to establish supporting policy. The state Medicaid program was a key stakeholder on the HMIHC pre-interconception work group. Efforts to establish and promulgate Medicaid policy continued through late FFY 2016.

OKQ®

A State team participated in the Boston CoIIN Session in July 2015. From this session, the team was introduced to OKQ®. The OKQ® screening protocol encourages providers to routinely ask women about their reproductive health needs and ensures that more pregnancies are wanted, planned, and healthy by asking "Would you like to become pregnant in the next year?" OKQ® was integrated into the HMIHC workplan to improve preventive health for reproductive age women. 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 health needs.

In January 2016, the HMIHC held a statewide meeting for public health and health care professional to roll out OKQ®. The keynote speaker was Michele Stranger Hunter, Executive Director of the OFRH which developed the OKQ® approach. Ms. Hunter also conducted OKQ® training sessions for providers on implementation of the screening tool into their practices.

The HMIHC pre-interconception work group expanded its plan to include OKQ® webinar trainings for clinical and non-clinician providers based on statewide interest in OKQ® implementation. Those trained included Women, Infant, and Children (WIC) workers, home visitors and family planning providers. Five thousand OKQ® brochures were printed and distributed to providers interested in the initiative.

The HMIHC and Title V focus on women's reproductive health planning (for healthy birth outcomes and to support women's personal health goals) were integrated into the Hawaii State Department of Health Strategic Plan 2015-2018. One of three strategic priorities in the plan include "Invest in Healthy Babies and Families." Objective A-1 specifically references OKQ® as an important screening protocol.

Other activities

The DOH Title X Family Planning Services program, administered by the Title V agency, provided 14,366 clients (21,998 visits) comprehensive statewide family planning services in FY2016. Services include client-centered education and counseling, pregnancy testing and counseling, basic infertility services, preconception health, sexually transmitted disease testing, and other related preventive health services (i.e. blood pressure screening, weight management and domestic violence and intimate partner violence screenings). 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 method and assess other health needs. As noted earlier, Family Planning providers are also utilizing the OKQ® screener and promoting LARC.

A scale was created to monitor/track progress made on the 5-Year plan strategies for HMIHC pre-interconception workgroup. Below is the completed scale for FFY 2016. Planning to continue working on this scale in FFY 2017.

Element	0 Not Met	1 Partially met	2 Mostly met	3 Completely met
asing Access to Reproductive Health Services				
Expand access to LARC and other contraceptive information by designing and conducting public and provider education.		X		
Encourage hospital in-patient pharmacy LARC stocking.		X		
Clarify LARC private health plan reimbursement, develop LARC chart and distribute LARC chart of coverage and coding for clinicians.				X
Hold clinical (family planning/primary care provider training, May 2016) and non-clinical (WIC and home visiting providers August 2016) OKQ® implementation training.				X
Develop OKQ® implementation plan			X	
Conduct contraceptive training for WIC and home visitation staff implementing OKQ®.			X	
ing/monitoring HMIHC Pre- Interconception work activities				
Develop more detailed tracking and metrics for HMIHC pre/interconception work plan activities.		X		
Develop and annually update the HMIHC pre/inteconception work plan activities as required to meet overall goal.			X	

Total Score (possible 0-21) ___13___

Report on Federal Fiscal Year 2017 (10/1/16 – present)

A variety of actions occurred during FFY 2017 that impact the ESM through the promotion of the two evidence based initiatives – LARC & OKQ®.

LARC/OKQ® Medicaid Policy

In November 2016, the Medicaid program released two memorandums formally supporting the use of OKQ®. The memorandums endorsed Medicaid providers screening for pregnancy intention through OKQ® for every woman at every visit. The Medicaid Memo No. QI-1613 One Key Question and Contraceptive Coverage includes 'the OKQ Algorithm' to assist providers with follow-up services depending on a client's response to the question. The memorandums also address potential barriers to use of LARC including reimbursement, stocking of the contraceptives for ready client access, and listed billing codes for providers. The Medicaid memos were disseminated 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 the HMIHC.

This new policy impacted Oahu birthing hospitals. Several are now establishing protocols for stocking LARC in their inpatient pharmacies. The HMIHC is discussing how to measure success of the policy and its implementation by Medicaid providers.

OKQ®

OKQ® implementation was widely accepted at health care facilities and service programs and quickly integrated into practice including WIC, family planning programs, and MIECHV providers. Based on these initial results, interest by other providers increased; thus, statewide training continued. By December 2016 there were over 120 providers trained and 2,706 individuals reached with OKQ®.

The annual HMIHC statewide conference was attended by public health and professional individuals representing 28 key agencies and programs. The meeting presented OKQ® implementation updates by the family planning, MIECHV, and WIC programs. Data collection efforts were also reviewed. Breakout sessions were conducted on LARC and OKQ®. Pre-interconception work group discussions collected important stakeholder input that was used to update/revise the HMIHC/Title V ESM work plan. This included development of a locally-produced OKQ® video by Ms. Hunter to promote the initiative and engage more providers.

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 may serve as future resources. More information was also being requested to assist non-clinical providers with discussions on contraceptive options and information including referrals. OKQ® training packet information was reviewed and approved for OKQ® training use.

On June 15, 2017 OKQ® training was held for over 50 providers from MIECHV home visitation, Med-QUEST health plans, and home visitors with the military New Parent Program with coordination from a MCHB contractor. Live streaming was available for home visitation providers not able to attend. A substantial portion of this training focused on contraceptive information including myths and facts. All MCHB home visitation contractors will be trained and 12 of the 14 family planning program contracts will implement OKQ® in 2017.

OKQ® information was also provided through other public health initiatives including a training on “Preparing for Zika: Prevention, Diagnosis, Counseling and Providing Family Planning Care for Non-Pregnant Women and Men of Reproductive Age in the Context of Zika”. The training was co-sponsored by the DOH and the California Prevention Training Center and included a discussion on using OKQ®.

Other Activities

Title V staff and HMIHC partners attended a training on Project Management provided by Hawaii MCH Leadership Education in Neurodevelopmental and Related Disabilities Program (MCH LEND) faculty to develop work plans to assure progress on the NPM 1 ESM. Existing HMIHC plans were used to formulate the Title V work plan which can be found in section V. Supporting Documents.

A Hawaii team attended the February 2017 Infant Mortality CoIIN Learning Session in Houston, Texas, sharing information on partnership building through the HMIHC and other state planning efforts targeting women of reproductive age.

The MCHB Chief along with Hawaii’s director and deputy director of health, state legislators, and the state insurance commissioner participated in the Centers for Disease Control and Prevention (CDC) “Winnable Battles” meeting and teen pregnancy prevention was one of the priority public health challenges selected. Resources for reproductive life planning can support unintended pregnancy including that for adolescents.

Factors Contributing to Success

The Title V agency capitalizes on key state and national resources to advance activities to improve women’s health that directly impact birth outcomes and infant mortality. These resources have included but not been limited to:

- The former Executive Office of Early Learning's Action Strategy Planning process which had been supported by the Governor's Office in conjunction with substantial funding commitment from the Hawaii Community Foundation/Omidyar Foundation (the former established by the founder of eBay),
- Selection and engagement in the 2013 National Governor's Association (NGA) Learning Network to improve Birth Outcomes, and
- Hawaii participation in the national COIIN.
- Strong partnerships most notably that with the Department of Human Services Med-QUEST Division resulting in the release of two memorandums supporting these evidence-based strategies.

In addition, Title V utilized resources of key partners to provide leadership, staffing and funding to sustain these collaborative efforts over the past three years. These resources are crucial since the MCHB staffing and management has been hampered by significant turnover, loss of staffing due to funding cuts over the past 5 years. An example of the collaborative use of resources include the funding for the state Coordinator for the HMIHC and CoIIN projects. The position is funded through the CDC Preventive Health and Health Services Block Grant (PHHSBG), administered by the DOH Office of Planning, Policy and Program Development. The CDC grant funding has been critical to sustaining the momentum and work of the HHMIHC and has also supported LARC activities and workforce training.

The March of Dimes Hawaii Chapter has also provided funding for activities including distribution of the Hawaii LARC Reimbursement Medicaid Guide, and Hawaii ACOG speaker attendance, OKQ® training, and has provided meeting space.

Challenges, Barriers

Some of the ongoing challenges to implementing activities include:

- Establishing, coordinating and implementing linkages to ensure timely data for monitoring project benchmarks,
- Staffing to oversee activities for the OKQ® implementation and related follow-up, and
- Potential provider barriers to LARC such as insurance coverage of device and on-site proctor insurance training for inexperienced providers.

National Performance Measure

NPM-1: Percent of women with a past year preventive medical visit

The 2020 Title V state objective is to increase the number of women who have a preventive medical visit to 65.0%. In 2015, 63.0% of women in Hawaii received a preventive medical visit, which failed to meet the state objective and was below the national estimate of 66.1%. The state objective for 2021 was carried over from 2020. This figure has increased from the proportion of women who received preventive medical visit in 2011 (55.0%). Higher risk groups could not be reported due to small numbers.

National Outcome Measure

NOM-2: Rate of Severe Maternal Morbidity

The related Healthy People 2020 objectives are to reduce maternal illness and complications due to pregnancy to 28% and to reduce the rate of maternal mortality to 11.4 deaths per 100,000. In data from 2014, the rate of Severe Maternal Morbidity (SMM) was 159.5 per 100,000 live births which was below the national estimate of 171.7. In Hawaii, the rate of SMM has increased since 2010 when the rate was 60.4. Higher risk groups could not be reported due to small numbers.

NOM-3: Maternal Mortality Rate

The related Healthy People 2020 objectives are to reduce maternal illness and complications due to pregnancy to 28% and to reduce the rate of maternal mortality to 11.4 deaths per 100,000. In data from 2011-15, the rate of Maternal Mortality was 11.8 per 100,000 live births which was similar to the Healthy People objective, and was below the national estimate of 21.9. In Hawaii, the rate of Maternal Mortality has declined since a recent high in 2006-2010 when the rate was 22.1. Higher risk groups could not be reported due to small numbers.

NOM-4.1: Percent of Low Birth Weight Deliveries

The Healthy People 2020 objective is to reduce low birth weight to 7.8%. In data from 2015, Hawaii's estimate (8.3%) was similar to the national estimate of 8.1%. There has been no change over time with 8.4% of births low birth weight in 2009. Higher risk groups included women under 20 years (9.8%) and 35 years and older (10.3%), non-Hispanic Black (11.1%), unmarried women (9.3%), women who had less than a high school education (10.0%), and women with private insurance (8.4%).

NOM-4.2: Percent of Very Low Birth Weight Deliveries

The Healthy People 2020 objective is to reduce very low birth weight to 1.4%. In data from 2015, Hawaii met that objective (1.3%) and was similar to the national estimate of 1.4%. There has been no change over time with 1.4% of births very low birth weight in 2009. Higher risk groups included women with multiple birth (10.1%), women under 20 years of age (1.9%), and non-Hispanic Black (2.6%).

NOM-4.3: Percent of Moderately Low Birth Weight Deliveries

The related Healthy People 2020 objective is to reduce low birth weight to 7.8%. In data from 2015, the proportion of Moderately Low Birth Weight (MLBW) was 7.0% which exceeded that objective but was above the national estimate of 6.7%. There has been no change over time with 7.0% of births MLBW in 2009. Higher risk groups included women 35 years and older (8.7%), women who had less than a high school education (8.7%), and non-Hispanic Black (8.5%).

NOM 5.1: Percent of preterm births (<37 weeks)

The Healthy People 2020 objective is to reduce total preterm births to 11.4%. In data from 2015, Hawaii exceeded that objective (10.1%), but was above the 2015 national estimate of 9.6%. Higher risk groups included women with some college education (21.2%) and women with less than a high school education (13.5%).

NOM 5.2: Percent of early preterm births (<34 weeks)

The Healthy People 2020 objective is to reduce live births at 32-33 weeks to 1.4%. In data from 2015, Hawaii did not meet that objective (2.7%) but was similar to the 2015 national estimate of 2.76%. Early preterm births have not changed in Hawaii since 2009 (2.8%). Higher risk groups included women with some college education (6.0%) and women with less than a high school education (3.5%), and non-Hispanic Black (4.2%)

NOM 5.3: Percent of late preterm births (34-36 weeks)

The Healthy people 2020 objective is to reduce late preterm births at 34-36 weeks to 8.1%. In data from 2015, Hawaii exceeded that objective (7.4%), but was still above the 2014 national estimate of 6.9%. Late preterm births have decreased in Hawaii since 2009 (8.3%). Higher risk groups included women with some college education (15.1%), women with less than a high school education (10.0%), and women 35 years and older (9.3%).

NOM-6: Percent of Early Term Births (37-38 weeks)

There is no related Healthy People 2020 objective for early term births. In data from 2015, the proportion of early term births was 27.9% which was higher than the national estimate of 25.0%. There has been no change over time

with 28.4% of births early term in 2009. Higher risk groups included women that were not married (29.1%), women with less than a high school education (29.4%), and non-Hispanic Black (30.9%).

NOM-8: Perinatal Mortality Rate

The related Healthy People 2020 Objective is to reduce the rate of fetal and infant deaths during the perinatal period (28 weeks of gestation to 7 days after birth) to 5.9 perinatal deaths per 1,000 live births and fetal deaths. In data from 2014, the rate of perinatal mortality was 5.0 per 1,000 live births which was below the national rate of 6.0. There has been no change over time with a rate of 6.0 in 2009. Higher risk groups included women that were under 20 years of age (12.3) and non-Hispanic Black (12.6).

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

The Healthy People 2020 objective is to reduce the rate of all infant deaths to 6.0 infant deaths per 1,000 live births. In data from 2014, Hawaii exceeded that objective (4.5 infant deaths per 1,000 live births), which was below the 2014 national estimate of 5.8 infant deaths per 1,000 live births and significantly below the 2013 estimate in Hawaii of 6.4. Infant deaths in Hawaii have decreased since 2009 (5.9 infant deaths per 1,000 live births). Higher risk groups include women under 20 years (11.3 infant deaths per 1,000 live births), and non-Hispanic Black (12.6 infant deaths per 1,000 live births).

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

The Healthy People 2020 objective is to reduce the rate of neonatal deaths to 4.1 neonatal deaths per 1,000 live births. In data from 2014, Hawaii exceeded that objective (3.3 neonatal deaths per 1,000 live births) and was below the 2014 national estimate of 4.0 neonatal deaths per 1,000 live births. Neonatal deaths in Hawaii have decreased since 2009 (4.4 deaths per 1,000 live births). Higher risk groups include non-Hispanic Black (12.0 per 1,000 live births).

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

The Healthy People 2020 objective is to reduce post-neonatal deaths to 2.0 deaths per 1,000 live births. In 2014, Hawaii met that objective (1.1 deaths per 1,000 live births) and was slightly below the 2014 national estimate of 1.9 deaths per 1,000 live births. Post neo-natal deaths have increased in Hawaii since 2009 (1.5 deaths per 1,000 live births).

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

In 2014, Hawaii experienced 177.9 preterm-related mortalities per 100,000 live births, which was lower than the 2014 national estimate of 211.4 mortalities per 100,000 live births. Preterm-related mortality has decreased in Hawaii since 2009 (233.0 per 100,000 live births). High risk groups include women under 20 years (599.4 per 100,000 live births).

Perinatal/Infant Health

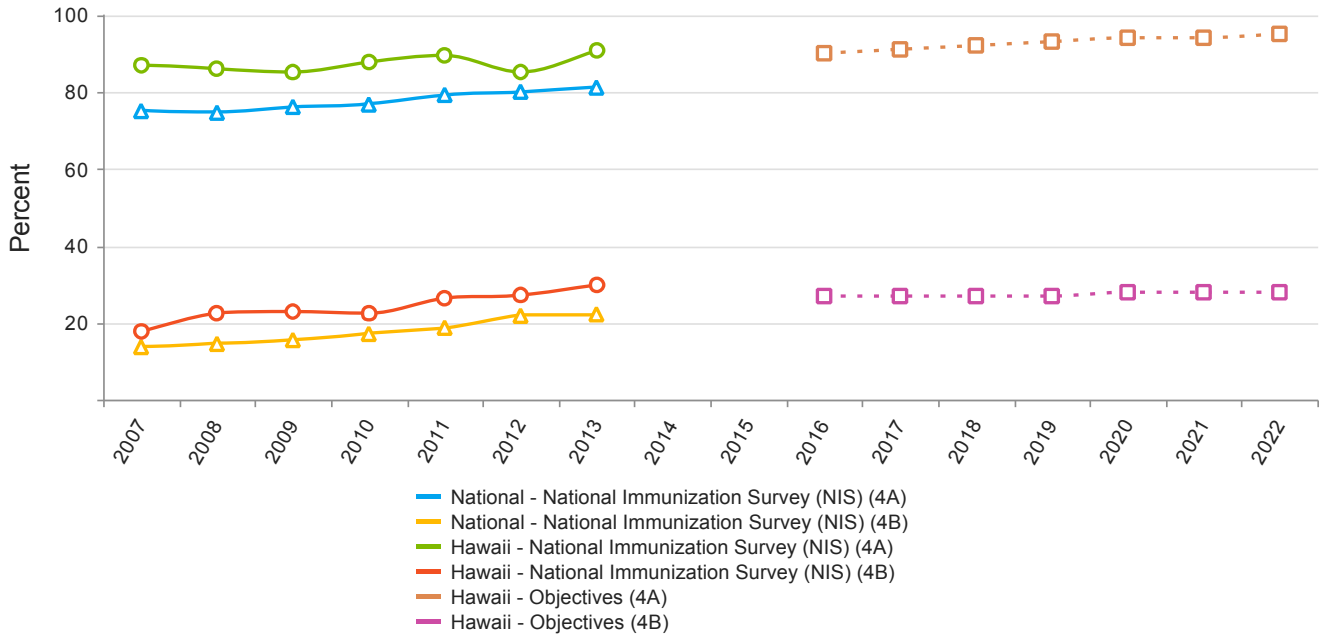
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	4.5	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.1	NPM 4 NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	Not Reportable	NPM 4 NPM 5

National Performance Measures

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

Baseline Indicators and Annual Objectives



NPM 4 - A) Percent of infants who are ever breastfed

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	90
Annual Indicator	90.6
Numerator	15,214
Denominator	16,789
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	91.0	92.0	93.0	94.0	94.0	95.0

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	27
Annual Indicator	30.1
Numerator	4,828
Denominator	16,071
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	27.0	27.0	27.0	28.0	28.0	28.0

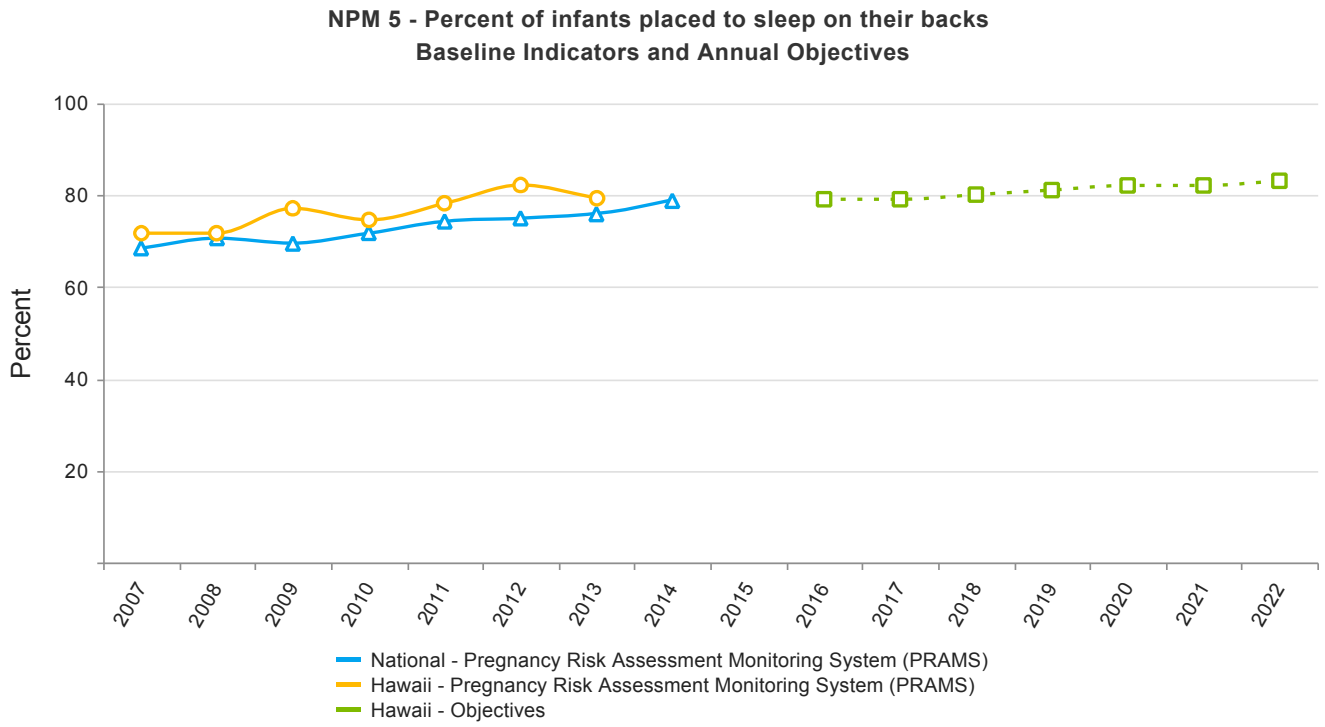
Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	80.6
Numerator	12,996
Denominator	16,132
Data Source	HI WIC Services Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	81.0	81.0	82.0	83.0	84.0	85.0



Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	79
Annual Indicator	79.2
Numerator	14,243
Denominator	17,975
Data Source	PRAMS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	79.0	80.0	81.0	82.0	82.0	83.0

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:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	66.7
Numerator	8
Denominator	12
Data Source	Safe Sleep Hawaii
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	60.0	70.0	80.0	90.0	100.0	100.0

State Action Plan Table

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

Priority Need

Reduce the rate of infant mortality

NPM

A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Objectives

By July 2020, increase the percent of of infants who are ever breastfed to 94% (Baseline: 2011 NIS data 89.5%)

By July 2020, increase the percent of infants breastfed exclusively through 6 months to 28% (Baseline: 2011 NIS data 26.4%)

Strategies

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

Use community-based organizations to promote and support breastfeeding.

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

NOMs

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

Percent of infants placed to sleep on their backs

Objectives

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

Strategies

Review birthing hospitals safe sleep policies.

Identify safe sleep competency training needs for birthing hospital professionals.

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	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

Priority Need: Breastfeeding

Breastfeeding continues to be a priority issue for Hawaii. Healthy People 2020 establishes initiation, duration and degree of exclusivity as nationally recognized benchmarks for measuring success. The 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 Collaborative Leaders Network's (CLN) Early Childhood Action Strategy (previously under the Executive Office on Early Learning) as an important practice to improve birth outcomes and reduce infant mortality.

The Title V agency, Family Health Services Division's WIC Services Branch is the largest public breastfeeding promotion program in the nation, providing mothers with education and support. In addition, WIC also provides breastfeeding training to service providers working with pregnant women and new mothers and WIC breastfeeding peer counselors (BFPCs) in select locations.

Although Hawaii breastfeeding rates compare relatively well to national averages, lower rates are associated with low-income households. Strengthening WIC breastfeeding programs provide a key opportunity to assure a healthy start in life for infants and improved health outcomes for postpartum mothers.

Priority: Reduce the rate of infant mortality by improving breastfeeding rates.

The state priorities focus on improving breastfeeding rates of infants ever breastfed and breastfed exclusively through 6 months and are based on the Title V National Performance Measures.

National Performance Measures:

A. Percent of infants who are ever breastfed and,
   B. Percent of infants breastfed exclusively through 6 months.

Objectives:

- By July 2020, increase the percent of infants who are ever breastfed to 94% (Baseline: 2011 NIS data 89.5%)
- By July 2020, increase the percent of infants breastfed exclusively through 6 months to 28% (Baseline: 2011 NIS data 26.4%)

The 5-year plan objectives were developed using the National Immunization Survey (NIS) data as a baseline and projecting a 5 percent improvement for infants ever breastfed and 6 percent improvement for infants exclusively breastfed at 6 months over the next five years.

5-Year Strategies:

- Strengthen programs that provide mother-to-mother support and peer counseling.
- Use community-based organizations to promote and support breastfeeding.

Strategy Development

The 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 CLN's Early Childhood Action Strategy office, HMIHC, the Perinatal Action Network, Healthy Mothers Healthy Babies and the March of Dimes.

Evidence/Expert Informed Strategy Measures (ESM)

The Evidence/Expert Informed Strategy Measures (ESM) is the percent of WIC infants ever breastfed. The measure is related to Strategy 1 and was selected based on Title V programmatic resources, the ability to achieve improvement, the availability of data, and technical assistance provided by AMCHP and the federal MCH Bureau.

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.

WIC is the largest public breastfeeding promotion program in the state and nation, providing mothers with education and support as a core service. WIC BFPCs provide additional support to families. 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.

Plans for Application Year Federal Fiscal Year 2018 (10/01/17-09/30/18):

Work on the two breastfeeding 5-year strategies will continue. Initiatives to promote breastfeeding at WIC can be found in the work plan in Section V. Supporting Documents. Some of the major activities include breastfeeding trainings, analyze WIC breastfeeding data, and explore ways to expand BFPC on the neighbor islands.

The breastfeeding state planning effort led by the HMIHC will continue in FFY 2018. The HMICH's Infant Health & Safety Team will refine 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 include:

- Continue conducting breastfeeding trainings for service providers to help mothers overcome common breastfeeding challenges.
- Refer all pregnant moms served by FHSD programs to Healthy Mothers Healthy Babies Text4Baby service.
- Continue collaborating with Chronic Disease Prevention and Health Promotion Division regarding supporting Baby Friendly Hospital related activities.

An update on progress will be provided in next year's Title V report and needed adjustments made to the 5-Year Plan.

Priority Need: Safe Sleep

Priority: Reduce the rate of infant mortality by promoting safe sleep practices.

The 5-year needs assessment confirmed the importance of providing safe sleep education and training to parents and childcare providers as a priority issue. Two important state maternal and child health improvement efforts - the Hawaii Maternal and Infant Health Collaborative (HMIHC) and Early Childhood Action Strategy – identified promotion of safe sleep practices as an important priority to improve birth outcomes and reduce infant mortality. HMIHC completed a strategic plan and accompanying Logic Model, *The First 1,000 Days*, aimed at achieving the outcomes of 8% reduction in preterm births and 4% reduction in infant mortality by 2018. HMIHC identified two priority strategies to achieve the objective of decreasing infant mortality in the first year of life, they are 1) to foster safe sleep practices for all who care for infants and 2) to provide professional development and training opportunities for caregivers of infants.

Since 2002, Safe sleep continues to be a part of the Title V Maternal and Child Health Branch (MCHB) program efforts. MCHB provides support and leadership for Safe Sleep Hawaii, a statewide partnership that promotes life-saving safe sleep techniques, policies and education for parents, teachers, health professionals, and other caregivers. Members include the Departments of Health, Education and Human Services, hospitals, military, child care agencies and the community.

In 2015, Safe Sleep Hawaii and safe sleep partners from the Hawaii Maternal and Infant Health Collaborative (HMIHC) joined together to participate in the national Infant Mortality Collaborative Improvement and Innovation Network (COIIN) as the Hawaii Safe Sleep Team. Through CoIIN, Safe Sleep Hawaii expanded its partnerships to include more hospitals, early child care partners, home visitors, parenting educators, nurses, physicians, parent advocates, and public and private agencies.

National Performance Measure: Percent of infants placed to sleep on their backs.

Objectives:

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

The preliminary 5-year plan objectives were developed using the Pregnancy Risk Assessment Monitoring System data as a baseline and projecting a 4 percent improvement over the next five years.

5-Year Strategies:

- **Review birthing hospitals safe sleep policies.** Identify, obtain, review, and monitor birthing hospitals safe sleep policies, protocols, or guidelines.
- **Identify safe sleep competency training needs for birthing hospital professionals.**
- **Develop appropriate and consistent parental education and general awareness safe sleep messages.** Identify decision-makers, key partners, and resources to develop safe sleep messages for parents and others who care for infants.

The wording of the strategies was revised slightly from last year's Title V report in response to suggestion made at the Title V review for clarity; however, the content/direction of the strategies has not changed.

Strategy Development

In the mid-2000s, all of Hawaii's birthing hospitals worked to establish hospital safe sleep policies to align with the AAP's guidelines for creating a safe sleep environment. Generic policy templates were sent to all facilities for adoption. When the AAP issued expanded guidelines in 2011, the birthing hospitals reported they were following safe sleep practices, but many had not formally adopted written policies. Without written policies for safe sleep, birthing hospital staff were not monitored for their knowledge of current AAP safe sleep guidelines and longtime employees may not have received updated training. Without written policies, hospitals were not required to inform parents on how to create a safe sleep environment for their infant.

Strategies were extracted from the Hawaii Safe Sleep Team's national CoIIN Initiative and refined by the Safe Sleep Title V workgroup. This workgoup includes staff from the Family Health Services Division who provide services that reach parents of infants such as managers from the Parenting Support Program, the Newborn Metabolic Screening Program, and the Newborn Hearing Program. Additional input was collected through in person meetings with representatives from the Family Health Services Division Medical Director, Neighbor Island District Health Office Nurses, Maternal and Child Health Branch, Women, Infants, and Children (WIC) Program, Hawaii

Home Visiting Program, and the Early Childhood Comprehensive Systems Program. Recommendations were also provided by the Keiki Injury Prevention Coalition, Safe Sleep Hawaii Partnership, and the Perinatal Nurse Manager's Task Force.

Evidence Based/Informed Strategy Measure

The Evidence Based/Informed Strategy Measure (ESM) selected for safe sleep is focusing on the strategy addressing birthing hospital policies and training needs of the hospital staff. The actual measure is "Percent of birthing hospitals with current American Academy of Pediatrics safe sleep protocols." Safe Sleep Hawaii will collect and report the data for this measure. The objectives for the ESM were set by the Safe Sleep Team and reflect 100% completion rate by 2020. See Form 10C for the Detail sheet.

Plans for Application Year Federal Fiscal Year 2018 (10/1/17-9/30/18):

The Title V safe sleep work group and Safe Sleep Hawaii will implement the activities outlined in the Safe Sleep work plan found in the Supporting documents. The plan outlines key activities for each of the three Safe Sleep strategies to effectively achieve the ESM 5.1. including child care and hospital policies, training, data, and message development. The oversight of hospital safe sleep training and the provision of safe sleep information to new parents leaving birthing centers will be assigned to the Perinatal Nurse Manager Task Force. DOH will provide ongoing technical support. Data and recommendations from child death reviews and PRAMS will continue to inform the refinement of safe sleep messages and materials targeting parents and others who care for infants.

Breastfeeding Report

Report on Federal Fiscal Year 2016 (10/1/15 – 9/30/16)

ESM 4.1/Strategy 1 Strengthen programs that provide mother-to-mother support and peer counseling.

The FFY 2016 ESM indicator is 80.6% of WIC infants ever breastfed from July 1, 2015 through June 30, 2016. WIC's breastfeeding promotion and support core services are overseen by the State Agency's designated Breastfeeding Coordinator. All WIC local agencies have a designated breastfeeding coordinator. WIC's added service Breastfeeding Peer Counseling (BFPC) Project, conducts monthly group sessions for pregnant and breastfeeding WIC moms to address breastfeeding concerns. WIC BFPC funds also support BFPC activities at 3 private WIC agencies as well as 3 state-run WIC agencies.

Specific activities in FFY 2016 to support the ESM include:

- December 2015 – 7 WIC staff attended Certified Lactation Counselor training to increase staff competency to support breastfeeding moms. The training was conducted by Healthy Children Project Inc.
- March 21-23, 2016 – A "Teaching Baby Behavior" train-the-trainer workshop conducted by Dr. Jane Heinig from UC Davis Human Lactation Center and Carol Melcher was offered to hospital administrators in charge of training, community organizations that support moms, birth and lactation providers and WIC administrative staff. Nine out of the 12 birthing hospitals statewide were represented at the workshop. A total of 23 hospital staff attended from the islands and hospitals: Kauai – Kauai Veterans Memorial Hospital, Wilcox; Oahu – Kapiolani, Kaiser Permanente Moanalua, Queens, Tripler, Castle; Maui – Maui Memorial; and Hawaii – Kona Community. There were also two home visitors, one breastfeeding coalition board member, one Healthy Mothers Healthy Babies staff, the WIC BFPC Coordinator and the WIC Breastfeeding Coordinator in attendance. The intended outcome of the training was to improve staff training care dimension score on CDC's Maternity Practices in Infant Nutrition & Care. and to have consistent messaging about baby behavior from community based organizations and hospitals.
- WIC staff refer participants to Healthy Mothers Healthy Babies Text4Baby service which provides pregnancy and postpartum text reminders which include breastfeeding and safe sleep messages.

The breastfeeding ESM was selected and reviewed by Johns Hopkins University staff providing TA for ESM development and by the MCH Bureau staff. Objectives were set to capture progress on this measure on an annual basis. At the August 2016 in-state Title V grant review the ESM received general approval.

Strategy 2 Use community-based organizations to promote and support breastfeeding.

Other Title V programs serving high-risk pregnant women offer an opportunity to promote breastfeeding through education and support services including the Maternal and Child Health Branch Perinatal Support Services program, and the Hawaii Home Visiting Network, supported by the Hawaii Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant. The Title V Early Childhood Comprehensive Systems (ECCS) coordinator also assisted to assure breastfeeding is integrated into state systems planning and services where appropriate.

Hawaii has an active state breastfeeding coalition, Breastfeeding Hawaii (BH), that works to promote, protect and support breastfeeding through collaboration and organization of community efforts, outreach, legislation, policy change, education, and advocacy. The state WIC breastfeeding coordinator is a board member of BH and serves as a liaison facilitating communication regarding breastfeeding matters between the CDC's Division of Nutrition, Physical Activity and Obesity and the United States Breastfeeding Coalition.

Report on Federal Fiscal Year 2017 (10/1/16 – present)

ESM 4.1/Strategy 1

The WIC breastfeeding promotion program efforts continue. The Title V breastfeeding staff attended training on Project Management provided by MCH LEND faculty in October 2016 to develop detailed work plans to assure progress on the ESM and the 5-year strategies. The work plans can be found in Section V. Supporting documents.

World Breastfeeding Week will be celebrated on August 5, 2017 at Waimanalo Health Center and was planned collaboratively with the WIC Breastfeeding Peer Counseling Program. The event will be open to the public and will highlight resources that could assist in the immediate postpartum period.

The WIC State Agency plans to complete a training needs assessment on breastfeeding topics by the end of the fiscal year. The survey will include WIC staff and the home visiting program.

Due to decreasing WIC caseloads and subsequent reduction in federal WIC funding, the WIC Branch implemented a reduction in workforce action in February 2017 to align WIC staffing with client numbers served. The WIC Breastfeeding/Outreach Coordinator position was eliminated as part of this action. Duties have been reassigned to existing staff. WIC will work on activities outlined in the breastfeeding work plan.

Strategy 2

To move statewide efforts towards promoting breastfeeding, the HMIHC Infant Health & Safety Team held a technical assistance meeting in April 2017 with Diane Spatz, PhD, RN-BC, FAAN to develop a Breastfeeding Logic Model and Strategic Plan. Professor Spatz is a faculty member at University of Pennsylvania and is recognized for many achievements in lactation support and care which include development of the 10 Step Model to Promote & Protect Human Milk and Breastfeeding in Vulnerable Infants. She is also credited with developing an evidence-based training program for breastfeeding resource nurses at The Children's Hospital of Philadelphia.

Breastfeeding trainings continued in 2017. In April 2017, Breastfeeding Hawaii hosted a 3-hour skills training workshop titled "Helping Families Succeed at Breastfeeding". The workshop was marketed to parents, healthcare providers, birth and lactation support providers, students and social service workers.

Later in May 2017, a refresher workshop with Carol Melcher on the *Secrets of Baby Behavior* training was conducted with those who attended the March 2016 training. 22 hospital staff were in attendance representing the following hospitals: Kauai – Kauai Veterans Memorial Hospital, Wilcox; Oahu – Kaiser Permanente Moanalua, Queens, Tripler, Castle; and Hawaii – North Hawaii, Kona Community. Also in attendance were 3 WIC State Agency staff, a staff member from Hawaii Public Health Institute, and a Family Support Services of West Hawaii home visitor.

Factors Contributing to Success

The FHSD WIC Services Branch breastfeeding promotion program and access to a large high risk population of pregnant women and young mothers are a major contributing factor for success.

The Affordable Care Act helped promote BF by requiring breast pump coverage through medical plans which can assist mothers with lengthening the duration of exclusive breastmilk feeding, especially as new mothers return to work or school.

Additionally, Title V utilized resources of key partners to provide leadership, staffing, and funding to sustain

community based activities beyond WIC. The coordinator for the Hawaii Maternal Infant Health Collaborative helped to convene breastfeeding stakeholders, coordinate statewide planning, and access national technical assistance resources. The Collaborative Leaders Network's (CLN) Early Childhood Action Strategy also continues to promote breastfeeding and is participating in HMIHC Breastfeeding Strategic Planning process. The Strategic Plan will be key in seeking resources for breastfeeding efforts such as creating and funding a State Breastfeeding Coordinator. CLN pays for neighbor island participants travel to attend day-long strategic planning meetings as well as hosts facilities and provides food for participants.

Other Title V programs serving high-risk pregnant women also offer an opportunity to promote breastfeeding through education, workforce training, and support services including 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. The Title V Early Childhood Comprehensive Systems (ECCS) coordinator also assisted to assure breastfeeding is integrated into state systems planning and services where appropriate. Promoting breastfeeding is included in the EOEL Early Childhood Strategic plan for the state.

Challenges, Barriers

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.

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. 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.

Another challenge is the national and local decline of WIC participation. Moms who would have had access to breastfeeding support through WIC may not have access to the support and follow-up provided by WIC and to the camaraderie shared with other WIC moms. Hawaii WIC data collection shows that of moms who stop breastfeeding in the infant's first year of life, the majority stopped breastfeeding in between 2-4 weeks of age with not having enough milk cited as the reason for stopping. Additional data collection is needed to determine if moms' responses are due to true milk insufficiency or formula supplementation

National Performance Measures

NPM-4A: Percent of infants who are ever breastfed

The 2020 Title V state objective is to increase the proportion of children who were ever breastfed to 94.0%. In 2013, the estimate for Hawaii (90.6%) failed to meet the objective, but exceeded the national estimate of 81.1%. The state objective for 2021 was carried over from 2020. The current estimate for Hawaii (90.6%) has not changed since 2011 (89.5%). Higher risk groups could not be reported due to small numbers.

NPM-4b: Percent of infants breastfed exclusively through 6 months

The 2020 Title V state objective is to increase the proportion of children who are breastfed exclusively through six months to 28.0%. In 2013, the estimate for Hawaii (30.1%) met the objective, and exceeded the national estimate of 22.3%. The state objective for 2021 was carried over from 2020. The proportion of children breastfed exclusively through six months has increased since 2011 (26.4%). Higher risk groups could not be reported due to small

numbers.

National Outcomes Measures

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

The Healthy People 2020 objective is to reduce post-neonatal deaths to 2.0 deaths per 1,000 live births. In 2014, Hawaii met that objective (1.1 deaths per 1,000 live births) and was slightly below the 2014 national estimate of 1.9 deaths per 1,000 live births. Post neo-natal deaths have increased in Hawaii since 2009 (1.5 deaths per 1,000 live births).

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

The Healthy People 2020 objective is to reduce the rate of infant deaths from sudden unexpected infant deaths to 84 deaths per 100,000 live births. In 2013, Hawaii exceeded that objective with 79.0 deaths per 100,000 live births and was below the 2013 national estimate of 87.0 deaths per 1,000 live births. The rate of SUID has decreased in Hawaii since 2010 (115.9 deaths per 100,000 live births). High risk groups include women aged 20-24 years (85.4 deaths per 100,000 live births). 2014 Hawaii data was not available in FAD due to small numbers.

Safe Sleep Report

Report on Activities Federal Fiscal Year 2016 (10/1/15 – 9/30/16)

The FFY 2016 indicator for ESM 5.1 is 66.7%. In 2016, all of Hawaii's birthing hospitals reported following safe sleep practices, however, only 8 of 12 (66.7%) formalized their safe sleep guidelines or procedures. The following is a status report on the Safe Sleep activities outlined in the detailed work plan in Section V. Supporting Documents. Activities completed are marked by a ✓. Ongoing activities are marked by ❖.

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Review birthing hospitals safe sleep policies.

Most activities for this strategy were completed following the Safe Sleep work plan.

- Identify point of contact at each birthing facility to provide a copy of the facility's safe sleep policies, protocols, or guidelines.
  - ✓ Status: The Perinatal Nurse Managers (PNMs) Task Force agreed to submit their facility's written safe sleep guidance, protocol, or policy to the DOH, Newborn Metabolic Screening Program (NMSP) Manager.
- Discussion of safe sleep protocols to be included in the Perinatal Nurse Managers Task Force quarterly meetings.
  - ✓ Status: Included as a standing agenda item.
- Monthly communication with PNMs for updates on policy status.
  - ✓ Status: DOH, NMSP Manager initiates and/or responds to safe sleep policy/protocol/guidance-related calls from the PNMs as needed.
- Convene PNMs annually to discuss safe sleep policy implementation.
  - ✓ Status: An in-person meeting was held in September 2016 to encourage the PNMs to promote safe sleep awareness month at their facilities.

Identify safe sleep competency training and monitoring of professionals.

Most activities for this strategy were completed as outlined in the work plan.

- Identify safe sleep trainings for hospital staff which are either free and/or available online.
  - ✓ Status: Presentation on the important role of hospitals in educating new parents on safe sleep practices. In January 2016, the Pediatrics Chairperson of the Queen's Medical Center, one of state's largest birthing

hospitals, was invited to share information and resources. Members of Safe Sleep Hawaii members spoke to pediatricians and encouraged the formal adoption of a safe sleep policy by the hospital.

- ✓ Status: The link to free online safe sleep training for nurses is through the National Institute of Child Health and Human Development (NICHD), was provided to the Perinatal Nurse Managers Task Force and Safe Sleep Hawaii partnership.
- ✓ Child & Family Service, one of Hawaii's largest non-profits serving families, provided safe sleep training to the following birthing centers: Kaiser Permanente Moanalua, Kahuku Medical Center, Tripler Army Medical Center, Kapiolani Medical Center, Kaiser Koolau Center, and at the Castle Medical Center.

Develop appropriate and consistent parental education and general awareness safe sleep messages.

Most activities for this strategy were completed as outlined in the work plan.

- Identify safe sleep resources to share with the Perinatal Nurse Managers Task Force
  - ✓ Status: Cribs for Kids Safe Sleep Champion buttons were purchased for labor and delivery staff working with parents at the birthing facilities. Charlies Kids board books were given to the Perinatal Nurse Managers for distribution to parents delivering babies during the month of October. Safe sleep materials from the National Institute of Health and Safe Sleep Hawaii were distributed to birthing facilities.
- Identify and/or purchase safe sleep materials for WIC, home visitors, and other community partners to promote October as Safe Sleep Awareness Month.
  - ✓ Status: Safe sleep materials from the National Institute of Health and Safe Sleep Hawaii were distributed to birthing facilities to WIC programs.
  - ✓ Status: David Ige, Governor of Hawaii, proclaimed October 2015, Infant Safe Sleep Awareness Month.
  - ✓ Status: In November 2015, the local NBC affiliate produced and aired a feature emphasizing the importance of educating new parents on safe sleep practices http://khon2.com/2015/11/25/hawaii-infants-prone-to-sleep-related-deaths-unsafe-sleeping-habits/.
  - ✓ Status: Safe Sleep Hawaii held its Annual Meeting. Work groups (Hospital Policies and Training; Licensed Child Care Policies and Training; Data / Child Death Review; and Public Awareness and Messaging) provided updates on their progress to address safe sleep practices.
  - ✓ Status: In July 2016, the Hawaii Home Visiting Network (HHVN) updated its Data Collection Plan Frequently Asked Questions (FAQ) to address network members' questions about harm reduction and safe sleep.
  - ✓ Status: Military efforts to promote Safe Sleep Awareness month included Safe sleep education and messaging shared with New Parent Support Programs and at the Tripler Army Medical Center (TAMC), the birthing center serving all branches of the military in Hawaii.
  - ✓ Safe sleep information shared with pediatricians at the September 2016 AAP Fall conference.
  - ✓ Safe Sleep Awareness Month promoted through videoconferencing with WIC site managers statewide in September 2016.
  - ✓ Healthy Mothers Healthy Babies provided safe sleep education and 60 cribs to parents through partnerships with community agencies and medical facilities on the islands of Oahu, Maui, and Kauai.

Report on Activities Federal Fiscal Year 2017 (10/1/16 – present)

Review birthing hospitals safe sleep policies.

- Monthly communication with Perinatal Nurse Managers for updates on policy status.
  - ✓ Status: DOH, Newborn Metabolic Screening Program Manager has provided technical assistance on hospital policy developments, as needed.

Identify safe sleep competency training and monitoring of professionals.

- Develop a process for ensuring/monitoring staff training.
  - ❖ Status: Discussion regarding safe sleep training of hospital staff is scheduled to occur during the June 2017 Perinatal Nurse Manger's Task Force Quarterly Teleconference.
- Provide opportunities for PRAMS staff or Child Death Review teams members to present data and/or recommendations to Safe Sleep Hawaii
  - ✓ Status: Alice Yang, Council of State and Territorial Epidemiologists (CSTE) Fellow, presented an initial analysis of PRAMS 2012-2013 data related to Safe Sleep. Preliminary data showed a very small decrease in back sleep positioning which will be monitored with the next release of PRAMS data.

Develop appropriate and consistent parental education and general awareness safe sleep messages.

- Identify hospital-based safe sleep education programs for (pilot) implementation in Hawaii
  - ✓ Kaiser Permanente includes the locally produced safe sleep video (http://www.safesleephawaii.org/) on the Kaiser's Patient Education Network. New parents can view the video during their delivery stay.
  - ❖ Status: The Kapiolani Medical Center for Women and Children is exploring the possibility of distributing Baby Boxes to new parents.
- Convene Safe Sleep Hawaii Partnership meetings
  - ❖ Status: Starting in 2017, Safe Sleep Hawaii meetings are scheduled to precede Keiki Injury Prevention Coalition (KIPC) meetings to encourage members to participate in both meetings.
- Plan and convene Safe Sleep Hawaii Annual Meeting
  - ❖ Status: A core group of Safe Sleep Hawaii members will begin meeting in June 2017 to plan the 2017 Annual Meeting scheduled for October 2017.
- Identify safe sleep resources to share with the Perinatal Nurse Managers Task Force.
  - ✓ Status: Parents were asked safe sleep related questions at an annual Children and Youth Day. The results indicated that while parents were aware that babies should be placed to sleep on their backs or use a crib, parents continued to use/include soft bedding (blankets, pillows, bumper pads, stuffed animals) or chose to sleep with their babies.
  - ❖ Status: A discussion on how the hospitals can support the promotion of October as Safe Sleep Awareness Month is scheduled to occur at the June 2017 Perinatal Nurse Manger's Task Force Quarterly Teleconference.
- Identify and purchase safe sleep materials for WIC, home visitors, and other community partners to promote October as Safe Sleep Awareness Month.
  - ✓ Status: The Hawaii Home Visiting Program ordered Charlies Kids safe sleep board books for distribution by local implementing agencies.
  - ❖ Status: A core group of Safe Sleep Hawaii members will review local and national safe sleep materials for distribution by community partners to parents.
- Identify individuals to develop a safe sleep awareness plan.
  - ✓ Status: Representatives from the Department of Health (DOH) and Department of Human Services (DHS) met to identify a small group to lead the development of a safe sleep public awareness messaging plan.
- Identify and develop relationships with partners to champion a safe sleep message.
  - ✓ Safe Sleep presentations were conducted and informational materials distributed statewide throughout the month of October.
  - ✓ During November 2016, local news outlet Honolulu Civic Beat published a series of articles related to deaths in child care facilities. Two of these "Mother Looks In Vain For Answers In Sons Day Care Death" (http://www.civilbeat.org/2016/11/honolulu-mother-looks-in-vain-for-answers-in-sons-day-care-death/) and "Hawaii Failed to Take Steps Meant to Prevent Day Care Deaths" (http://www.civilbeat.org/2016/11/hawaii-failed-to-take-steps-meant-to-prevent-day-care-deaths/) mention sleep related deaths in licensed child care.
  - ✓ In March 2017, DHS Director, Pankaj Bhanot and DOH Director, Dr. Virginia Pressler authored "Don't be silent about protecting sleeping infants from harm" http://www.staradvertiser.com/2017/03/27/editorial/island-voices/dont-be-silent-about-protecting-sleeping-infants-from-harm/ in the Sunday edition of the Honolulu Star Advertiser newspaper that has subscribers statewide. The article encourages parents to have open conversations about safe sleep with the people who care for their children. The article includes the AAP's 2016 guidelines and let the

public know about the safe sleep-specific rules DHS promulgated, along with local online resources.

- Review social media and traditional safe sleep messages used in other states.
  - ❖ Led by the DOH and DHS, Safe Sleep Hawaii will develop new safe sleep materials and launch a public awareness campaign by the end of 2017. Community partners (including parents) will be asked to participate in the message development and promotion of safe sleep materials.

Factors Contributing to Success

Advocacy by safe sleep champions. One of the significant factors for success is the formation of Safe Sleep Hawaii,in 2002. by Dana Fong. Mr. Fong is a a grandfather who became a safe sleep champion after experiencing the personal loss of his granddaughter on her first day in childcare. Mr. Fong continues to advocate for greater awareness of safe sleep information by professionals, parents, and caregivers.

Media reports and articles of Family Champions. Local news coverage on local infants who have died due to unsafe sleep practices helped raise public awareness of safe sleep as an important public health issue. The coverage of the family's efforts to assure system changes at the Legislature garnered important support from policy makers, providers, and state agency directors to prioritize safe sleep initiatives.

CoIIN Technical Assistance. The efforts of Safe Sleep Hawaii were bolstered by national efforts to reduce infant mortality through the national Infant Mortality Collaborative Improvement and Innovation Network (COIIN).

Collaboration. Members from Safe Sleep Hawaii joined with the Hawaii Maternal and Infant Health Collaborative (HMIHC) to engage new partners in promoting safe sleep strategies to reduce infant deaths. Safe Sleep Hawaii co-founder Gwen Palmer, RN, utilized her relationships with perinatal nurses through her work overseeing the state's Newborn Metabolic Screening Program to review hospital safe sleep protocols. Discussion with the perinatal nurses about the importance of having written guidelines in place and addressing safe sleep education/training led to the increase in number of hospitals who have formally adopted written guidelines.

Restoration of Child Death Review (CDR). In 2016, HMIHC and other safe sleep partners successfully advocated at the Legislature for the appropriation of funds to the DOH to conduct child death reviews (CDRs) and implement a program to perform maternal death reviews. In June, a statewide CDR training was held for stakeholders, staff and members of the CDR council. Act 203 was signed into law by the Governor on July 5, 2016. By reviewing infant deaths related to unsafe sleep practices, awareness messaging can be improved or targeted to address needs from specific communities or populations.

Challenges

While Hawaii has many dedicated safe sleep advocates and partners, efforts to develop a universally adopted training on safe sleep practices has been difficult due to the established, but understated practice of bed sharing among local families. The general acceptance of bed sharing is anecdotally attributed to the state's ethnic/cultural diversity and 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. Training and policies were updated to include the 2016 expanded recommendations set by the American Academy of Pediatrics (AAP). The AAP recommends that infants sleep in the parents' room, close to the parents' bed, but on a separate surface designed for infants, ideally for the first year of life, but at least for the first six months. However, parents continue to choose to sleep with their babies. Discussion focuses on how to provide safe sleep education to parents in a way that engages them in making informed decisions on how to create as safe an environment as possible within the context of their living situation

and values.

National Performance Measure

NPM-05 – Percent of infants placed to sleep on their backs

The 2020 Title V state objective is to increase the proportion of infants placed to sleep on their backs to 82.0%. Data from 2013 showed that Hawaii did not meet that objective (79.2%), but exceeded the national estimate of 75.8%. The state objective for 2021 was carried over from 2020. The proportion of infants placed to sleep on their backs has increased from 2011 (78.1%). Higher risk groups could not be reported due to small numbers. Data from 2014 PRAMS survey was not available at time of reporting.

National Outcome Measures

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

The Healthy People 2020 objective is to reduce the rate of all infant deaths to 6.0 infant deaths per 1,000 live births. In data from 2014, Hawaii exceeded that objective (4.5 infant deaths per 1,000 live births), which was below the 2014 national estimate of 5.8 infant deaths per 1,000 live births and significantly below the 2013 estimate in Hawaii of 6.4. Infant deaths in Hawaii decreased since 2009 (5.9 infant deaths per 1,000 live births). Higher risk groups include women under 20 years (11.3 infant deaths per 1,000 live births), and non-Hispanic Black (12.6 infant deaths per 1,000 live births).

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

The Healthy People 2020 objective is to reduce post-neonatal deaths to 2.0 deaths per 1,000 live births. In 2014, Hawaii met that objective (1.1 deaths per 1,000 live births) and was slightly below the 2014 national estimate of 1.9 deaths per 1,000 live births. Post neo-natal deaths increased in Hawaii since 2009 (1.5 deaths per 1,000 live births).

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

The Healthy People 2020 objective is to reduce the rate of infant deaths from sudden unexpected infant deaths to 84 deaths per 100,000 live births. In 2013, Hawaii exceeded that objective with 79.0 deaths per 100,000 live births and was below the 2013 national estimate of 87.0 deaths per 1,000 live births. The rate of SUID decreased in Hawaii since 2010 (115.9 deaths per 100,000 live births). High risk groups include women aged 20-24 years (85.4 deaths per 100,000 live births). 2014 Hawaii data was not available in FAD due to small numbers.

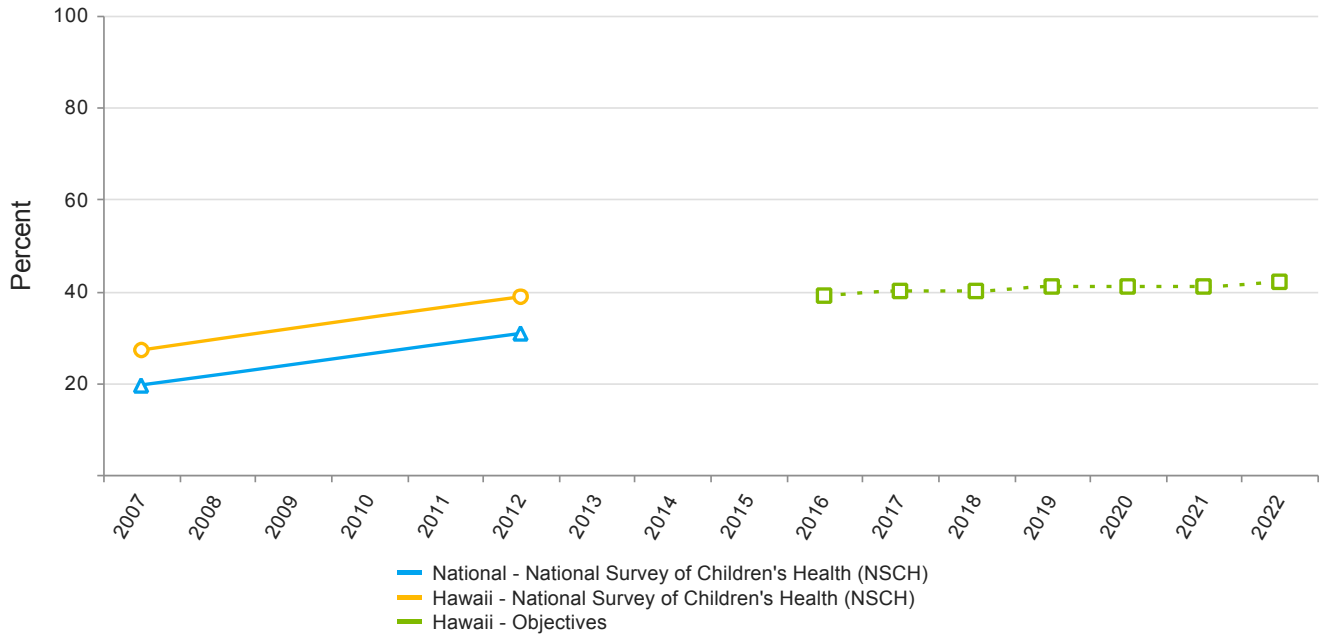
Child Health

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	NPM 6
NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000	NVSS-2015	14.4	NPM 7
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	27.0	NPM 7
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	9.6	NPM 7
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	11.2	NPM 7
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	86.0 %	NPM 6

National Performance Measures

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	39
Annual Indicator	38.9
Numerator	31,440
Denominator	80,906
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	40.0	40.0	41.0	41.0	41.0	42.0

Evidence-Based or –Informed Strategy Measures

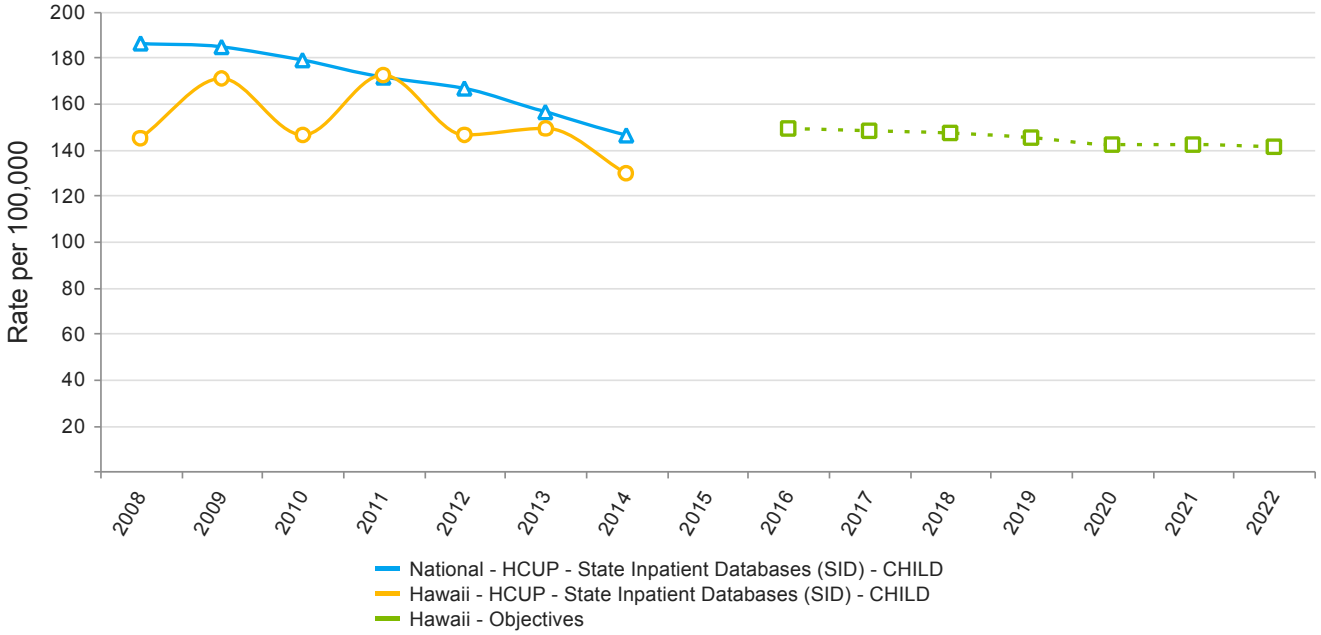
ESM 6.1 - Development and implementation of Data sharing system for FHSD programs conducting developmental screening, referrals, and services

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Program Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
Baseline Indicators and Annual Objectives



NPM 7 - Child Health

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - CHILD	
	2016
Annual Objective	149
Annual Indicator	129.6
Numerator	231
Denominator	178,298
Data Source	SID-CHILD
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	148.0	147.0	145.0	142.0	142.0	141.0

Evidence-Based or –Informed Strategy Measures

ESM 7.1 - Percent of children in a home visiting program with an injury-related visit to the emergency department since enrollment.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	1
Data Source	N/A
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.1	0.1	0.1	0.1	0.1	0.1

ESM 7.2 - Number of participants who attend trainings and receive technical assistance on promoting safe, healthy, and respectful relationships.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

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

Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Objectives

By July 2020, increase the percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool to 41% (Baseline: 2011-2012 NSCH data 38.9%)

Strategies

Systems Development - develop guidelines and a tool kit for early childhood providers and health professionals on the developmental screening, referral, and services system for children birth-5 years old, and provide trainings on these resources.

Family Engagement and Public Awareness - work with families and parent organizations to develop family-friendly material to support understanding of the importance of developmental screening.

Data Integration – develop an internal data sharing system which will be able to monitor # of children screened from Maternal and Child Health Branch (MCHB) Home Visiting Programs, Children with Special Health Needs Branch (CSHNB) Hiʻilei Program, Family Health Services Division (FHSD) Early Childhood Comprehensive Systems Impact (ECCS Impact) and number of referrals to Early Intervention Section (EIS), and number of children receiving services from EIS.

Policy and Public Health Coordination - develop within FHSD an infrastructure for developmental screening, referral, and services for children ages birth-5 in FHSD programs using a PPHC Rating Scale.

Social Determinants of Health and Vulnerable Populations – identify and support vulnerable populations as related to social determinants of health to target and outreach efforts for child screening and development.

ESMs	Status
ESM 6.1 - Development and implementation of Data sharing system for FHSD programs conducting developmental screening, referrals, and services	Active

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children in excellent or very good health

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

Priority Need

Reduce the rate of child abuse and neglect with special attention on ages 0-5 years.

NPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Objectives

By July 2020, reduce the rate of hospitalizations for non-fatal injuries in children aged 0-9 and 10-19 years to 142 per 100,000 population (Baseline: 148.9 in 2010)

Strategies

Raise awareness about the importance of safe and nurturing relationships to prevent child abuse and neglect.

Provide training and technical assistance to promote safe, healthy, and respectful relationships to prevent child abuse and neglect.

Collaborate on and integrate child wellness and family strengthening activities and programs.

ESMs	Status
ESM 7.1 - Percent of children in a home visiting program with an injury-related visit to the emergency department since enrollment.	Active
ESM 7.2 - Number of participants who attend trainings and receive technical assistance on promoting safe, healthy, and respectful relationships.	Active

NOMs

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

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

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

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

Priority Need: Developmental Screening

Priority: Improve the percentage of children screened early and continuously age 0-5 years for developmental delay.

Hawaii continues to focus on developmental screening as a priority issue based on results of the 5-year needs assessment. At both the state and federal levels, developmental screening has surfaced as a lever to help improve the health and well-being of children and families.

At the federal level, Health Resources Services Administration (HRSA) identified improving children's developmental health as a priority as evidenced in the Early Childhood Comprehensive Systems Impact (ECCS Impact) grant focusing on developmental screening activities of young children birth through age 3. Hawaii received the ECCS Impact grant in 2016 focusing on the county of Maui and developmental screening of three year olds using the Ages and Stages Questionnaire-3 (ASQ-3). This grant works in partnership with the federal Maternal Infant and Early Childhood Home Visiting (MIECHV) program which is implemented in Hawaii through the Department of Health (DOH) Maternal and Child Health Branch (MCHB) Home Visiting Services Unit. The MIECHV program has a benchmark focusing on the percentage of children who have received developmental screening and coordination and referral for services.

At the state level, the Hawaii Department of Health developed its five-year strategic plan and identified developmental screening, referral, and services as a priority. The Executive Office on Early Learning is developing an early childhood strategic plan that has a priority around child development and developmental screening. The public-private collaborative, Action Strategy for Hawaii's Children, is working on establishing a universal, voluntary screening-referral-utilization system starting with developmental screening (DS) of young children birth through age five. The Hawaii Chapter of the American Academy of Pediatrics (HAAP) identified developmental screening beginning at infancy through the early elementary school years as a priority. The Hawaii State Council on Developmental Disabilities is also addressing developmental screening in their strategic plan and partners with FHSD on many activities.

At the FHSD level, the Title V Developmental Screening Work Group (Title V Screening Work Group) continues to address the integration and infrastructure issues focusing on developmental screening and services within the Division since several programs incorporate the screenings into their scope of services. MCHB Home Visiting providers administer ASQ-3 and Ages and Stages Questionnaire-Social Emotional (ASQ-SE) to parents, CSHNB Hi'ilei Program provides developmental screening and follow up for children birth-5 using the ASQ-3, EIS provides the services as the IDEA Part C Agency, and FHSD ECCS Impact grant is working on developmental screening on Maui County. The FHSD Nurses in the Counties continue to provide information and guidance in the development of community-based strategies and raise community issues around vulnerable populations.

Additionally at FHSD, the Centers for Disease Control and Prevention (CDC) MCH-Assigned Epidemiologist completed a data review based on the National Survey of Children's Health (NSCH) 2011/12 data. Data from the NSCH identified that in Hawaii, there were disparities in moderate/high risk for delay for race and insurance type. White children had the lowest risk for delay compared to other racial groups. Significantly more Asians (30.0%), Native Hawaiian and Pacific Islanders (42.0%) and multiracial (26.7% children had moderate/high risk for delay compared to Whites (13.5%) although the estimate for Whites was unreliable (>39%RSE). Differences in risk for delay were seen between federal poverty level groups but were not significantly different. Publicly insured children (37.9%) had the highest rate for moderate/high risk for delay. Differences between publicly insured children

compared to privately (24.5%) and uninsured (11.0%) children were significant, although the estimate for uninsured children was unreliable (>30%RSE). Hawaii will meet with Hawaii's Medicaid agency (Department of Human Services Med-QUEST Division) to address this disparity. There were no statistically significant disparities in moderate/high risk for delay with respect to child's gender.

The state priority is based on the Title V block grant guidance National Performance Measure for developmental screening on children. This is a continuing priority issue for children from the previous 5-year needs assessment.

National Performance Measure: Percent of children, ages 10 months through 17 months, receiving a developmental screening using a parent-completed screening tool.

Objective: By July 2020, increase the percentage of children, ages 10 months through 71 months, receiving a developmental screening using a parent-completed screening tool to 41% (Baseline:2011-2012 NSCH data 38.9%).

The 5-year plan objectives were developed using the baseline 2011-2012 data from the National Survey of Children's Health. Annual objectives were developed projecting a 5% improvement over the next five years.

5-Year Plan Strategies:

The strategies for developmental screening were modified slightly to align with the six evidence-based primary drivers model made available through the ECCS Impact grant Collaborative Improvement and Innovation Network (CoIIN). The CoIIN Primary Drivers are: Early Identification of Developmental Needs; Systems Promote Developmental Health and Meet Needs of Children and Families; Family Engagement; Linked and Coordinated Data Systems; Advocacy and Policy Change; Social Determinants of Health. The last strategy on social determinants was added onto the strategies in last year's report.

- Systems Development (Early Identification of Developmental Needs and Systems Promote Developmental Health and Meet Needs of Children and Families) - Hawaii partners will develop guidelines and a tool kit for early childhood providers and health professionals on the developmental screening, referral, and services system for children birth-5 years old, and provide trainings on these resources.
  - Finalize guidelines and guidance sheet for screening, referral, and services.
  - Work with partners to develop infrastructure for ongoing training, technical assistance, and support for providers conducting developmental screening activities.

- Family Engagement and Public Awareness (Family Engagement) - Hawaii Title V programs will work with families and parent organizations to develop family-friendly material to support understanding of the importance of developmental screening.
  - Work with families and parent organizations to develop family-friendly material explaining importance of developmental screening and how to access services.
  - Develop website to house materials, information, and resources on developmental screening.

- Data Integration (Linked and Coordinated Systems) – Title V Screening Workgroup will develop an internal data sharing system to monitor the number of children screened from MCHB Home Visiting Programs, CSHNB Hiʻilei Program, and number of referrals to Early Intervention Section (EIS).
  - Revise data system for internal tracking and monitoring of screening, referral, and services data.
  - 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 (PPHC) (Advocacy and Policy Change) – Title V Screening Workgroup will assess its implementation efforts using the PPHC Rating Scale to monitor progress on the screening, referral, and services infrastructure. Each year the Title V Screening Workgroup will assess its efforts and activities and make adjustments as needed.

- Social Determinants of Health and Vulnerable Populations (Address Social Determinants of Health) - Title V Screening Workgroup will identify and support vulnerable populations and target outreach efforts for screening and promoting child development.

Strategy Development

The strategies were developed by the workgroup with consideration of other statewide and nation-wide efforts on developmental screening in Hawaii. This workgroup includes staff from other Title V programs, many of whom have been working on the issue for the past five years, and additional partners brought in based on their interest and their efforts supporting the work. These strategies also include input from the community through the Collective Impact work of the group Hui Kupaʻa which is focused on two geographic communities, but had direct service providers involvement. Additional stakeholder input was collected through meetings, online surveys for information and feedback, and participation at conferences and other public events such as informational displays at local community conferences. The strategies were then sent for review by Johns Hopkins University who provided critical feedback and helped the group refine both the ESM and other strategies. Additional information from the ECCS CoIIN added a strategy focusing on vulnerable populations and was a reaffirmed that the Screening Workgroup strategies are in alignment with national efforts.

Evidence-Expert Informed Strategy Measure

The Evidence-Expert Informed Strategy Measure (ESM) selected for developmental screening is focusing on the creation of a data sharing system within FHSD to collect the number of screenings, referrals, and services provided to children (ages birth-5) in the MIECHV Home Visiting Programs, the CSHNB Hi'ilei Program, and EIS. Once the data sharing system is developed, FHSD can document the number of children being screened and tracked through referral into services across Division programs. For Quality Improvement (QI), this data sharing will help pinpoint where increases in screenings, referrals, and follow up are needed. It may also identify areas of duplication or monitor where screenings are occurring but referrals are not. The MIECHV and Hi'ilei programs were selected because the programs use the same screening tool (ASQ-3) and serve the vulnerable populations in need of monitoring. MIECHV Home Visiting services target families identified through a risk assessment conducted in the hospital. Hi'ilei was originally designed to serve children who were not eligible for EIS but are still in need of monitoring and follow up. These two programs service high-risk and vulnerable populations of children where timely services can help improve optimal development.

The actual measure is "Development and implementation of data sharing system for FHSD programs conducting developmental screening, referrals, and services." The measure is tracked by a Yes or No. Yes refers to whether the data sharing system has been developed and implemented. No indicates the establishment of a data sharing system is still in progress. See Form 10C for the Detail sheet.

Once the system is in place, the ESM will be adjusted to address the needs as identified by the data and implementation of the Policy and Public Health Coordination matrix scale to measure infrastructure building to support developmental screening, referral, and services.

Plans for Application Year Federal Fiscal Year 2018 (10/1/17-9/30/18):

Plans for the development of the FHSD developmental screening data system include:

- Make final determination on system

- Develop operation manual for data system
- Produce report content and access
- Establish data collection study for quality improvement

Work on the developmental screening 5-year strategies will continue. The Title V Screening Work Group will also oversee implementation of Title V screening efforts of the Policy and Public Health Coordination strategies. The focus for FY 2018 is to continue work with partners to implement the statewide system for developmental screening, referral, and services. Community level initiatives and input will be used to refine statewide policies, procedures and guidelines.

Hawaii will revise the FHSD data collection system to improve screening efforts to help increase the number of children screened using a validated parent questionnaire. The Work Group and partners will continue to address the five developmental screening strategies: system development, family engagement and public awareness, data integration, policy and public health coordination, and social determinants of health and vulnerable populations as reflected in the detailed work plan in Section V. Supporting Documents.

A Policy and Public Health Coordination Elements Rating (PPHCER) scale 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 2017 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 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 Rating Scale.				
8. Conduct process for bi-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				

Priority Need: Child Abuse and Neglect Prevention

Priority: Reduce the rate of child abuse and neglect with special attention on ages 0-5.

Child abuse and neglect (CAN) prevention is a continuing priority from the previous Title V needs assessment and relates to the Title V child injury hospitalization national performance measure.

The Title V agency has a statutory role in CAN prevention and administers several major programs dedicated to CAN prevention, violence prevention, and family strengthening, including the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant under the Home Visiting Program (HVP), Sexual Violence Prevention Program (SVP), Domestic Violence Prevention Program (DVP), Parenting Support Program (PSP), and the Community-Based Child Abuse and Prevention (CBCAP) grant under the Child Abuse and Neglect Prevention Program (CAN Program). These programs are housed in the Hawaii State Department of Health (DOH), Family Health Services Division (FHSD), Maternal and Child Health Branch (MCHB), Family Support and Violence Prevention Section (FSVPS).

Star-Advertiser

Facing child abuse: Changes 20 years after Kema case

The 2015 Hawaii 5-year needs assessment reaffirmed the importance of CAN prevention as a continued priority issue with policymakers and the community. Child maltreatment remains a health concern, with routine coverage in the local media of high-profile CAN cases raising the need for improved primary prevention services and agency responsiveness.

Data from the State of Hawaii Department of Human Services (DHS) Child Welfare Services (CWS) show CAN rates have largely remained unchanged. CWS specializes in intervention and treatment, including secondary and tertiary prevention. Spurred by legislative requests, the DOH and DHS are working on strengthening the relationship between the FSVPS and CWS to improve the continuum of services to prevent and respond to violence against children. The programs worked to improve the understanding of each programs' purpose, to work together across disciplines, and to share data to inform and guide program strategies to prevent and reduce the number of confirmed CAN cases.

The table below presents DHS confirmed CAN data from 2011–2015. It is difficult to determine the cause for the increase. With the largest population, Honolulu County has the highest number of CAN cases.

Confirmed Child Victims by County, 2011-2015					
Children (duplicated count)*					
County	**2011**	**2012**	**2013**	**2014**	**2015**
Hawaii	334	306	284	347	425
Honolulu	732	750	761	727	766
Kauai	89	103	81	107	111
Maui	219	233	203	225	266
Total	**1,424**	**1,392**	**1,329**	**1,406**	**1,568**

The following table shows confirmed CAN cases are highest among the infant age group. This suggests the importance of programs starting early to promote safe, healthy, and respectful families, educate young families on the impact of children exposed to violence, and support nurturing parenting education and parent support. Most CAN cases occurred among children 0-5 years; thus, the state priority focuses on early childhood.

Confirmed Child Victims by Age, 2011-2015					
Children (duplicated count)*					
Age	2011	2012	2013	2014	2015
< 1 Year	224	224	236	272	273
1 Year	116	97	98	98	110
2 Years	86	97	90	89	105
3 Years	108	93	79	79	97
4 Years	96	89	87	78	89
5 Years	104	91	83	81	78

Source: State of Hawaii, Department of Human Services, Child Abuse and Neglect in Hawaii, 2015, https://humanservices.hawaii.gov/wp-content/uploads/2016/08/2015-CAN-report-print.pdf

***Duplicated count**: A child is counted each time he/she was confirmed as a victim and therefore may be counted more than once during the reporting period.

National Performance Measure: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19.

The state priority to reduce the rate of CAN with attention to ages 0-5 does not completely align with the overall Title V Child Health national performance measure (NPM); however, the state priority is related to NPM 7. Children affected by CAN are a subset of the total number of children captured by the NPM.

Objective: By July 2020, reduce the rate of hospitalizations for non-fatal injuries in children aged 0-9 and 10-19 years of age to 142 per 100,000 population (Baseline: 148.9 in 2010)

5-Year Strategies: The NPM strategies were revised slightly from last year. The strategy on evaluation was replaced with a new strategy to provide training/technical assistance to promote safe, healthy, and respectful relationships to prevent child abuse and neglect. This reflects a need in the service system and a new program initiative. The third strategy was reworded per the comments from last year's Title V grant review.

- Raise awareness about the importance of safe and nurturing relationships to prevent child abuse and neglect.
- Provide training and technical assistance (TA) to promote safe, healthy, and respectful relationships to prevent child abuse and neglect.
- Collaborate on and integrate child wellness and family strengthening activities among programs.

Strategy Development:

The strategies reflect the work of the previous Governor's Executive Office of Early Learning Action Strategy Initiative for "Safe and Nurturing Families". Although the Early Learning Action Strategy Initiative has moved out of the Governor's Office, its work continues as an important private-public partnership. The strategies also reflect guidelines promoted by the Centers for Disease Control and Prevention (CDC) to prevent child maltreatment.

Prior to the 2015 needs assessment, the MCHB leadership recognized that violence takes many forms (i.e., child maltreatment, intimate partner violence, sexual violence, and suicidal behaviors) and is interconnected with the various MCHB violence prevention programs. However, the violence prevention programs largely operated in silos. To encourage greater collaboration and integration, an MCHB reorganization plan was approved in 2012 to create the FSVPS to house all the violence-related programs. The Title V strategies were developed by the MCHB and FSVPS to support this work.

The Title V strategy to improve integration and collaboration has helped prioritize this effort and led to monthly meetings for eighteen (18) months expressly to implement this strategy. The FSVPS worked to identify areas of common interest across the programs including shared core principals, common risk factors, root causes of violence, populations served, and stakeholder groups. The FSVPS also affirmed the common need to promote protective factors and safe, healthy, and respectful relationships, one of the three strategies. Additionally, the FSVPS programs recognized that the multiple forms of violence often share common root causes and that CAN plays a significant role across all the programs.

The collaboration process within FSVPS is path breaking, integrating the latest research, literature, and national frameworks – adverse childhood experiences (ACEs), the impact of children exposed to violence, social determinants on health, areas of integration among violence prevention programs, protective factors, and healthy relationships. By collaborating and pooling resources on specific topics based on CAN prevention, the FSVPS programs can reach a larger audience that will speak the same language and have the same understanding. This commonality will encourage programs and disciplines to implement best practices in service delivery and to work together collaboratively and in a coordinated fashion to end CAN and other forms of violence. Initial FSVPS-sponsored trainings on ACEs and impacts of violence on children's brain development and health assisted in identifying the multiple links among violence and are well-received by community stakeholders. To address the service system's need for education, FSVPS established a violence prevention collaborative (VPC) specifically to provide training and technical assistance to service providers statewide. Thus, a new strategy on training and technical assistance replaced last year's strategy to improve evaluation among the FSVPS programs.

Evidence Based/Informed Strategy Measure

ESM 7.1 - The Evidence Based/Informed Strategy Measure (ESM) selected for CAN utilizes one of the measures from the HVP because of its direct relationship to the NPM injury prevention focus and the evidence-based approach used by the program. The actual measure is "percent of children in a home visiting program with an injury-related visit to the emergency department since enrollment." This is a new measure for the HVP. Data for this measure will be reported to the HVP by service providers. The children tracked by this measure represent "index" children who enter the HVP prenatally or at birth, but not older siblings or subsequent siblings. Baseline data for the measure will be generated next year and objectives set. See Form 10C for the Detail sheet.

ESM 7.2 - Created this year to reflect the new strategy to provide training and TA to promote safe, healthy, and respectful relationships to prevent CAN. The measure will report the number of participants who receive training and TA by the FSVPS VPC. Based on an average of approximately four (4) trainings per year with approximately 100 people per training, not including TA, the VPC expects to train approximately 400 people per year. The VPC also plans to develop webinars in the near future, which may produce an increase in the numbers trained. See Form 10C for the Detail sheet.

Plans for Application Year Federal Fiscal Year 2018 (10/1/17-9/30/18)

ESM 7.1 - Data for ESM 7.1 will be reported for FFY 2018. The data for 2018 will be available in November 2018 and will be included in next year's report. Activities to reduce emergency department visits due to injury-related causes will include:

- Implementation of consistent accurate and complete data collection;
- Monitoring monthly reporting of ESM 7.1 measures;
- Offering Continuous Quality Improvement (CQI) with local implementing agencies who fail to reduce emergency department visits due to injury-related causes;
- Providing SVIPP education training to home visitors. The training modules include a child and family safety

curriculum (e.g., infant safe sleep, shaken baby, car seat and window safety);
- Reporting injury prevention techniques implemented in home visiting participant's homes; and
- Continue presenting information to home visiting participants on prevention of child injuries, including traumatic brain injury, poisoning, fire safety, water safety, and playground safety.

ESM 7.2 - The VPC will continue to build capacity for DOH MCHB and its partners to provide pertinent and relevant CAN-related trainings by attending leadership trainings, conducting training needs assessment surveys, and identifying partners to create a comprehensive and sustainable partnership training framework.

CAN Training Needs Assessment Survey

To inform MCHB of the community's need for CAN prevention (and related) trainings, a pilot survey was developed for Title V issue leaders. The pilot survey feedback will be used to further refine and implement a statewide needs assessment survey which will be distributed to State and County agencies and service providers during FY 2018.

Core CAN Prevention Partnership Group

A core partnership group, comprised of public-private representatives, will be formed in FY 2018 to help guide planning for the year's training/TA schedule. The needs assessment survey results will be analyzed and shared with a core partnership group. Suggested members of the group include the DOH Injury Prevention and Control Section, DOH Child and Adolescent Mental Health Branch, MCHB WRHS, DHS CWS, Department of the Attorney General, Hawaii State Coalition Against Domestic Violence, Hawaii Coalition Against Sexual Assault, Domestic Violence Action Center, The Sex Abuse Treatment Center, First Relationships-Infant Mental Health, the Keiki Injury Prevention Coalition (KIPC), and a parent leadership group.

The VPC and the core partnership group will develop statewide opportunities to provide consistent, on-going violence prevention trainings, specifically to promote safe, nurturing, and healthy relationships and guidance towards the inclusion of common language of CAN prevention training for all contracted providers as a requirement of all MCHB contracts.

Your Ohana Network

With the positive branding of Hawaii's home visiting network as Your Ohana, the VPC will assist and support the roll-out of the refreshed program and services, aimed to recruit prenatal women and families with infants, toddlers, and young children. The program hopes to increase awareness of home visiting services and impact maternal and child health outcomes, particularly to share child injury prevention education which includes the prevention of CAN.

Safe and Nurturing Families Framework

The VPC staff will continue to attend the Early Childhood Action Strategy Initiative's Safe and Nurturing Families Workgroup. The public-private partnership group will be developing a Safe and Nurturing Families Framework to prevent violence using a three-pronged strategy by including: 1) Outreach and awareness for families with young children and the general public; 2) Training for early childhood providers aligned with key messaging; and 3) Referrals to family supports, services, and programs. A proposal is being submitted to contract the services of a consultant to develop the framework to strengthen Hawaii's systems of support for families and reduce family violence in homes with young children.

The VPC-led training framework involves plans to include special populations who may be at greater risk for CAN including children with developmental disabilities, homeless youth and families, how to interview children exposed to violence, and Lesbian, Gay, Bi-Sexual, Transgender, and Questioning/Queer (LGBTQ) youth. MCHB

also encourages continued discussions with MCHB's WRHS, DHS, the Children's Justice Act Task Forces, the Department of the Attorney General, and the Judiciary around a comprehensive continuum of child abuse prevention, from primary to tertiary, and includes families and communities.

FHSD will continue to work on this priority area as discussed in the Title V plan. Progress updates will be provided in next year's Title V report.

Developmental Screening Report

Report on Federal Fiscal Year 2016 (10/1/15 – 9/30/16)

The FFY 2016 ESM indicator is *YES* since efforts to create the FHSD database are in place. Currently data exists from the FHSD programs and more work will be done to improve data collection. In the future, Hawaii is considering the use of the Ages and Stages Questionnaire Enterprise System (ASQ-Enterprise) which would collect screening data from multisite programs. The benefit of the ASQ Enterprise is that it would help to analyze screening results for children, generate program reports, and show trends across multiple screening programs. Data would still need to be collected from EIS to monitor the number of referrals made and received. Substantial progress was made to develop and collect data including:

- Development of policies & procedures around data collection;
- Defining the data fields that would be collected and by whom;
- Evaluating data and revising collection processes as needed;
- Implementing the data system.

Since the programs are only aggregating this developmental screening data, and no personal information is being shared, it was decided that no data sharing agreement is needed at this time amongst the participating Title V programs. The work group decided to report the number of children screened by calendar year (January – December 2016) and only count the number of 1 year olds and 2 year olds screened using the Ages and Stages Questionnaire-Social Emotional (ASQ-SE) (Home Visiting) and the ASQ-3 (Home Visiting and Hi'ilei) tool. Below is the 2016 data on number of one and 2 year olds screened, number of children referred, and number of referrals received by EIS. With this baseline data, Hawaii will be able to measure increases on screenings, referrals, and children receiving services.

DOH Home Visiting Screenings

ASQ:SE and ASQ-3: 24 Months (1-1-16 to 12-31-16)	
# of children screened at 24 months	218
# of children within the referral range	7
# of children referred	3
ASQ:SE and ASQ-3: 12 Months (1-1-16 to 12-31-16)	
# of children screened at 24 months	164
# of children within the referral range	11
# of children referred	4

Hi'ilei Data

# of Children referred to Hi'ilei	27
# of children scored below cut off	8 (but none of those were the 12 or 24 month screen)
# of ASQ 12-month screens returned	1
# of ASQ 24-month screens returned	2

Early Intervention Section Referrals Received

Referral Source	Jan. - Mar. 2016	Apr. - Jun. 2016	Jul. – Sept. 2016	Oct. – Dec. 2016	2016 TOTAL Jan. - Dec.
DOH Home Visiting	1	7	5	3	**16**
CWS Home Visiting	5	6	9	8	**28**
TOTAL:	**6**	**13**	**14**	**11**	**44**

Highlights on the for FFY 2016 progress for the 5-year strategies follows.

Strategy Area	Activities	Status
Systems Development	• Draft Guidelines for "Developmental Screening and Referral Guidelines for Early Childhood and Community-Based Screeners" developed with Action Strategy for Hawaii's Children. • Guidelines vetted with early childhood providers at Developmental Screening Conference. • Developmental Screening Workgroup member, Kauai FHSD nurse, worked with the Na Lei Wili Area Health Education Center to conduct interviews and follow up visits to approximately 30 family practice and pediatric doctors on Kauai to identify concerns and overcome barriers. A guideline based on the "Developmental Screening and Referral Guidelines for Early Childhood and Community-Based Screeners" and consent form was developed for Kauai professionals which was shared with the primary care providers and nurses.	• Draft guidelines are being vetted with stakeholders. • Kauai's sharing information on draft guidelines and identified concerns and developed draft consent form may be a model for developing the system by working within the community.
Family Engagement and Public Awareness	A Developmental Screening, Referral, and Services Conference "It's About Time: Developmental Screening, Referral, and Services" was held in July 2016 to approximately 80 early childhood providers including home visitors, Head Start and center based providers. The purpose of the conference was to share information and updates and vet a "Developmental Screening and Referral Guidelines" document with attendees.	Statewide conference on developmental screening conducted to share with stakeholders what Title V and other activities on developmental screening is happening.
Data Integration	Title V Screening Workgroup met to discuss the need for an integrated data system internally within FHSD.	Group committed to sharing data to determine if FHSD/Title V programs are increasing the number of children screened and referred and receiving services.
Policy and Public Health Coordination	Title V Screening Workgroup developed the Rating Scale and needs to develop how and when data will be collected.	Group will begin implementing once the process is in place
Social Determinants of Health	Title V Screening Workgroup discusses concerns heard in the communities about children in need of screening and services.	Group needs to collect data to assess the concerns.

Report on Federal Fiscal Year 2017 (10/1/16 – present)

Highlights on the for FFY 2017 progress for the 5-year strategies follows.

Strategy Area	Activities	Status
Systems Development	Conducted comprehensive developmental screening training to Family Child Care Providers working on accreditation which includes a standard on developmental screening. Four-part training included: Training on the ASQ-3 tool; Resources and Referrals; Engaging with the Medical Home; and Family Engagement.	Based on the training, group needs to develop better family engagement strategies as provides are still using the screening as an assessment tool rather than as a screening tool.
Family Engagement and Public Awareness	• A train the trainer on the ASQ-3 and ASQ:SE2 will be conducted in June to home visitors and ECCS Impact Community Partners that will be jointly funded by the MIECHV and ECCS Impact grants. This will lead to greater networking of home visitors and early childhood providers receiving refresher information on the ASQ-3 and new information on the ASQ_SE2. • Met with Community Children's Council Office and shared the Developmental Screening activities happening on Maui thru ECCS Impact Grant.	Need to engage with family members/groups to determine family-friendly messaging on importance of developmental screening.
Data Integration	Specific to Title V is the internal data integration where data to monitor the number of children screened from MCHB Home Visiting Programs, CSHNB Hiʻilei Program, and the number of referrals to CSHNB EIS, and the number of children receiving services from EIS. Data will be used for quality improvement purposes to see where changes in policies or procedures may lead to better outcomes for children and families.	Data submitted but needs better collection points.
Policy and Public Health Coordination	Title V Screening Work Group reviewed the PPHC assessment scale.	Workgroup leader submitted baseline data for a score of 6.
Social Determinants of Health	• FHSD Nurse on Hawaii Island raised a concern around the needs of the Micronesian community and other immigrants as a vulnerable population where targeted conversations on child development is needed. • Maui identified children experiencing homelessness as a population where development may be at risk because of their living situation. • Kauai raised a concern about the community health centers may not necessarily be addressing the child population.	Workgroup is continuing to monitor the situation and discuss with other stakeholder groups.

The Title V Screening Work Group attended training on Project Management provided by MCH LEND faculty in October 2016 to develop work plans to assure progress on the ESM and the 5-year strategies. The work plans can be found in Section V. Supporting documents.

Factors Contributing to Success

Partners diligently worked on the developmental screening priority for the past five years and many are long standing champions promoting children's optimal health and development. Factors contributing to success can be attributed to: partnerships with the medical home, utilizing public-private partnerships, focusing on data and outcomes, building on existing federal and state resources, and internal integration among FHSD programs.

- Partnership with the Medical Home: Developmental screening is part of a well-child visit and the responsibility is with the medical home to ensure children's development is being monitored. The draft guidelines on developmental

screening and referral were shared with the American Academy of Pediatrics – Hawaii Chapter. There was a concern that pediatricians were the referral point and could cause a delay in timely evaluation. To address this, one of the guideline states: "Programs who conduct the screenings should share the screening results with the primary care provider including the status of the screening results and if a referral was made to Early Intervention or DOE Preschool Special Education." Having a trusting relationship with the HAAP has helped to ensure pediatricians are on the same page with the guidelines.

- Public Private Partnerships: Hawaii's non-profit and community-based organizations play a major role in supporting efforts on developmental screening. These partnerships and relationships are crucial to developing a statewide system and ensures that the voices of both the community and providers are considered. These organizations also help sustain and build capacity in local communities. Partners include the Hawaii Association for the Education of Young Children, the Hawaii Head Start Association, PATCH (the Child Care Resource and Referral agency which provides community-based trainings statewide), and the Department of Human Services Child Care Program which oversees the Child Care Development Block Grant and the Action Strategy. By working together towards a common goal, Hawaii has been able to leverage resources and expertise from various partners.

- Data & Evaluation: Currently data sharing is being tested for 1 and 2 year olds in the Home Visiting and Hi'ilei program to see how many referrals are receiving services from the EIS. Even though the data collected was not consistent across programs, this first step will lead to an eventual optimal system. The team members need more guidance and discussion on the data collection elements. Although there were challenges with the data, the Workgroup is continuing to improve integration and collaboration to assure better health outcomes for children.

- Federal Alignment: Because HRSA funds both the Title V, MIECHV and ECCS grant, there have been opportunities at the state level to align and combine the work on developmental screening. Because the ECCS, Title V, and the MIECHV grants are all housed within the FHSD the coordinators maintain a good working relationship.

Challenges

Three challenges remain in the areas of a lack of policy on developmental screening, not having accessible EPSDT data to drive actions, and the public's lack of understanding about developmental screening.

- Policy: Hawaii's DOH does not have a policy on developmental screenings. The DOH does not have direct influence over other state agencies responsible for conducting developmental screenings (health care and early childhood providers) thus a general policy would not be effective. However, as the public health agency, standard policies, guidelines, or protocols would assist community providers and support the infrastructure for the system. This would also help the DOH work with both the Departments of Education and Human Services, which oversees public education, child welfare and the Medicaid program, to align efforts. The Developmental Screening Guidelines were developed to address the lack of policy.

- Partnership with Medicaid: Approximately 40% of Hawaii's children are insured through Medicaid. However, EPSDT data is not readily available for analysis to determine which communities may have challenges with screening and follow-up services. Only state-level utilization rates on the CMS 416 form are available which is not helpful to identify disparities and target interventions. Hawaii continues to collaborate with Med-QUEST (Hawaii's Medicaid program) to address these concerns.

- Public Awareness on Importance of Developmental Screening. There is still a lack of awareness on the importance of developmental screening. The messaging around developmental screening has always emphasize the purpose to identify children who have a developmental delay. Consumers need information to understand what the screening entails, the purpose, and how it helps support child development. Hawaii continues to work with family groups to address this issue.

National Performance Measure

NPM-6: Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

The 2020 Title V state objective is to increase the proportion of children, ages 10 through 71 months, receiving a developmental screening using parent-completed screening tool to 42.0%. Data from 2011-2012 show that the estimate for Hawaii (38.9%) failed to meet the objective, but exceeded the national estimate of 30.8%. The state objective for 2021 was carried over from 2020 as no data has been available to assess progress for several years. The proportion of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool has increased since 2007 (27.3%). Higher risk groups could not be reported due to small numbers. Data from 2016 survey not available at time of reporting.

National Outcome Measures

NOM-13 Percent of children meeting the criteria developed for school readiness

This measure is under development. There is no federally available data at this time.

NOM-19: Percent of Children in Excellent or Very Good Health

There are no related Healthy People 2020 Objectives. In data from 2011-12, the percent of children in excellent or very good health was 86.0% in Hawaii which was similar to the national estimate (84.2%). There has been no change over time with 86.7% in 2003. Higher risk groups could not be reported due to small numbers. Data from 2016 survey not available at time of reporting.

Child Abuse and Neglect Prevention Report

Report on Federal Fiscal Year 2016 (10/1/15 – 9/30/16)

ESM 7.1 - There is no data available to report for FFY 2016 on ESM 7.1 at this time.

In the FFY 2016, the HVP collected data on the outcome measure, "Visits for children to the Emergency Department (ED) from ***all causes*** (illness and injury)". This measure was reported as the total number of ED visits by index children in the program for at least 1 year (numerator) and total number of index children in the program for at least 1 year (denominator). Twenty-six percent (26%) of index children (77/301) in the program for at least 1 year were reported to have had an ED visit for any cause.

However, the HVP now has a new outcome measure more specific to injury prevention. The new outcome measure "Number of nonfatal injury-related visits to the Emergency Department by Index Children" was implemented and data collection among home visiting providers began October 1, 2016. At the time of this report a full year of data has not been collected on the ESM. Data for 2016 will be available in November 2017 and will be included in next year's report.

The Hawaii HVP activities to reduce injury among HVP families focus on:

- Information provided or training of home visiting participants on prevention of child injuries, including safe sleep, shaken baby, traumatic brain injury, child passenger safety, poisoning, fire safety, water safety, and playground safety; and
- Data Collection Tool Kits for all assessment tools used to evaluate each child in the home visiting program starting at two (2) months of age. During the final months of the FFY 2016 period the Tool Kit was revised to include the new measure, ***Number of nonfatal injury-related visits to the Emergency Department by Index Children,*** that went into effect October 1, 2017.

- A revised Took Kit and technical assistance were provided to each local implementing agency (LIA) at evidence-based model meetings and via teleconference. In addition, each LIA received a site-visit during the months of August and September 2016. This afforded each LIA the opportunity to review the revised Tool Kit with the HVP staff and make adjustments specific to each LIA's program.

A report on the progress for the two on-going and one deleted CAN prevention strategies follows.

Strategy 1: Raise awareness about the importance of safe and nurturing relationships to prevent child abuse and neglect.

Each FSVPS program focuses on violence prevention, increasing protective factors and decreasing risk factors, and healthy relationships as common themes. The program target audiences also overlap, i.e., CAN, HVP, and PSP work with children, youth, parents, and families while SVP and DVP include children, youth, and adults.

FSVPS programs coordinate annual events to raise awareness to prevent child abuse and neglect. April is Child Abuse and Prevention Month, and the most recognizable and striking visual for our families and communities is the blue and silver pinwheel, known as *Pinwheels for Prevention*, a national symbol for child abuse prevention. Sexual Assault Awareness Month is also recognized in April with events and activities to highlight sexual assault as a public health, human rights, social justice issue and reinforce the need for prevention efforts. The teal ribbon symbolizes sexual assault awareness and prevention, including child sexual abuse. October is Domestic Violence Awareness Month (DVAM) with statewide activities that promote peace in families, homes, and communities. The community, supported by state, county, and non-profit agencies, organizes the Hawaii Men's March, which is one of the major DVAM activities that seeks to bring together all those opposed to violence against women and children.

For families with children ages five (5) and younger, the HVP provides supportive parent education and nurturing activities with the overarching purpose of improving the health and well-being of families, as well as promotes child development, encourages positive parenting, and works with caregiver participants to set attainable goals for the future.

Strategy 2: Improve evaluation capacity of Title V Family Support and Violence Prevention Section programs to assure improved outcomes. (will be deleted in 2017 report)

As part of the FSVPS collaboration/integration work, program outcomes and evaluation methods were shared across the programs. Although this strategy was deleted, FSVPS is committed to evaluate program outcomes and improve evaluation methods to measure the collective impact of the FSVPS programs.

Strategy 3: Collaborate on and integrate child wellness and family strengthening activities among programs.

In addition to building greater integration in FSVPS, there are substantial areas for collaboration across the larger Title V Division, DOH, and community.

To ensure statewide reduction of CAN, the FSVPS partners with the DOH, FHSD District Health Offices (DHO) on Maui, Kauai, and Hawaii Islands to provide violence prevention trainings and TA. The DHO staff will assure collaboration and integration of CAN prevention with community-based programs and promote family engagement for child and family wellness services in their rural communities. In addition, DHO staff also participate in the Child Welfare Citizen's Review Panel, contributing recommendations for continuous improvement around CAN prevention.

The CAN Prevention Ho'oikaika Partnership on Maui was instrumental in providing Maui County coalition members with training and education around the Protective Factors (PF). Ho'oikaika aims to increase PF knowledge and skills for parents and caregivers and uses a family-centered approach for family strengthening. This approach reinforces the CDC's recommendations to promote family support and connectedness at the relationship level of the social-ecological model.

The community-based Teen Alert Program (TAP808), supported by the FSVPS DVP and CAN Program, together with the MCHB Women's and Reproductive Health Section (WRHS), provide statewide education and awareness of teen dating violence.

Collaboration continues with the Department of Education's Early Childhood Action Strategy Initiative. This statewide public-private collaborative brings together government and non-government organizations to align priorities for children prenatal to age eight and to strengthen and integrate the early childhood system by streamlining services, maximizing resources, and improving programs to support our youngest children. MCHB's program leads in CAN, DVP, and SVP are active and supporting participants in the Safe and Nurturing Families Workgroup. The goals of the group are to reduce the actual cases of family violence in homes with young children and strengthen early childhood providers' capacity to educate families on the protective factors and refer at-risk families when needed.

Report on Federal Fiscal Year 2017 (10/1/16 – present)

ESM 7.1 - The HVP started collecting data on the ESM measure from HVP providers. The data for 2016 will be available in November 2017 and will be included in next year's report.

The Hawaii HVP activities for the measure focused on:

- Implementation of Data Collection Toolkit guidelines for accurate and complete data collection beginning October 1, 2016; Monitoring monthly reporting of ESM 7.1 measures;
- Offering Continuous Quality Improvement (CQI) with local implementing agencies who fail to reduce emergency department visits due to injury-related causes;
- Collaboration with DOH Injury Prevention and Control Section and CDC Core State Violence and Injury Prevention Program (SVIPP) to establish injury prevention training for home visitors and monitoring of injury prevention techniques implemented in home visiting participant's homes; and
- Continue providing information to home visiting participants on prevention of child injuries, including safe sleep, shaken baby, traumatic brain injury, child passenger safety, poisoning, fire safety, water safety, and playground safety.

The HVP recent branding of its program as *Your Ohana* network (*Ohana* in Hawaiian means family) supports Strategy 1 to inform more of Hawaii's local families about the HVP's valuable services and aims to increase recruitment, enrollment, and retention of families with children ages 0-5 years. Similar branding has occurred nationally to address negative associations with home visiting programs being tied to child welfare services.

Strategy 2: Provide training and technical assistance to promote safe, healthy, and respectful relationships to prevent child abuse and neglect.

Much of the CAN prevention work for FFY 2017 focuses on the development, ground work and planning for the new strategy. As described in the "Strategy Development" section, the FSVPS programs met regularly to improve FSVPS program collaboration and established a VPC focusing on training and TA to reduce CAN. The VPC trainings will focus on topics generally not available, but of great interest to the violence prevention community

including the interconnection of multiple forms of violence, the short and long-term impacts of children exposed to violence, ACEs, protective factors, and promoting safe, healthy, and respectful relationships. The trainings will help to expand the community's understanding of violence, help inform service delivery (e.g., best practices), and build systems coordination.

The inclusion of training and TA as a new strategy to reduce CAN offers the VPC the opportunity to annually keep track of the number of those attending the trainings and receiving TA (see ESM 7.2).

To build capacity to provide CAN prevention training and TA, the newly formed VPC strengthened partnerships, increased knowledge and awareness of the impact of children exposed to violence, increased knowledge and understanding of best practices (e.g., trauma-informed approach, social ecology), and promoted positive behaviors and attitudes to change social and cultural norms.

The VPC staff attended a Title V Project Management training in October 2016 led by the Hawaii MCH Leadership Education in Neurodevelopmental and Related Disabilities Program (LEND) to develop detailed work plans for CAN prevention work and identify key policies, products, programs, initiatives, and event outcomes for the planned activities. Through the planning process, the focus on providing training and TA emerged as the primary strategy for the FSVPS.

To build leadership and skills to undertake the VPC work, FSVPS staff were integrated into LEND training opportunities including the Association for Talent Development CORE4 Conference; Mediation for Managers; Facilitation Training; and Design for Behavior Change. The VPC continues to receive professional development under the supervision of a LEND faculty mentor.

In addition, the VPC staff attended trainings during in FFY 2016 and 2017 to expand their knowledge of child abuse, domestic violence, and sexual violence, including cultural competence and violence among at-risk populations including the LGBT community. The CBCAP New State Lead Orientation provided valuable insight of how the CBCAP grant can be leveraged to support the development of the partnership training framework over the next five (5) years.

Concurrently, the VPC continued to develop and organize trainings, integrating ACEs research and best practices. If these traumatic experiences are not addressed, the effects can be passed from one generation to the next. The goal is to reduce the rate of CAN by addressing the impact of children exposed to violence, as well as by promoting safe, healthy, and respectful relationships.

The following are CAN prevention-related trainings provided by the VPC for MCHB contracted service providers, government agencies, and community partners. DOH MCHB staff were encouraged to attend trainings to increase knowledge of CAN issues and provide opportunities for cross-training to broaden understanding of the links among violence.

CAN Prevention Trainings Provided by VPC			
Type of Training	**Date**	**Title**	**Target Audience/ Location**
CAN Prevention	10/2-3/2015	The Period of PURPLE Crying	Home Visitors/Statewide
SV Prevention	11/12/15	Promoting Well-Being	SVP Team Leaders/Statewide
SV Prevention	11/13/15	Annual DOH SVP Training: Planting the Principles of Prevention	DOH & SVP Community Action Teams/Statewide
CAN Prevention	10/3/2015	Hawaii Cribs for Kids: Impacting Sleep Related Deaths through Education	Home Visitors/Statewide
SV Prevention	1/8/16	Sex Trafficking in Hawaii: Prevention and Intervention	DOH & Community Providers/Maui
SV Prevention	1/11/16	Sex Trafficking in Hawaii: Prevention and Intervention	DOH & Community Providers/Kauai
SV Prevention	1/15/16	Sex Trafficking in Hawaii: Prevention and Intervention	DOH & Community Providers/Oahu
SV Prevention	1/25/16	Sex Trafficking in Hawaii: Prevention and Intervention	DOH & Community Providers/Hilo
DV Prevention	10/21/16	DV 101	Developmental Disabilities Case Managers/Oahu
SV Prevention	12/1/16	Annual DOH SVP Training: Engaging Men and Boys as Allies to Prevent SV	DOH & SVP Community Action Teams/Statewide
CAN Prevention	1/25/2017	The Period of Purple Crying Program	Home Visitors/Statewide
CAN Prevention	1/26/2017	Child Maltreatment in Hawaii: What do I need to know? What do I do?	Home Visitors/Statewide
ACEs	1/25-26/2017	Children Exposed to Violence/ACEs 1.0	DOH & Home Visitors/Statewide
ACEs	1/26/2017	Children Exposed to Violence/ACEs 2.0	DOH & Service Providers/Kauai
SV Prevention	1/31/17	Cyber-Sexual Exploitation of Minors	DOH & SVP Providers/Statewide
SV Prevention	1/31/17	[respect] Toolkit Training	DOH & SVP Providers/Statewide
DV/SV Prevention	3/16/17	19th Annual Kau Rural Health Association Conference	Service Providers & Community Members/Kau

Factors Contributing to Success:

- CAN prevention is a long-standing issue in child health with a high level of public awareness and support in Hawaii. There is strong legislative and administrative support for child maltreatment as a priority health concern.
- The "new" Title V guidance provided an opportunity to collaborate and align MCHB's CAN prevention efforts while addressing the identified State priority need. The new 5-year plan template helps focus discussions in the VPC, as well as communicate the programs' common agenda around CAN prevention.
- MCHB's HVP, CAN Program, DVP, SVP, and PSP are all housed in the FSVPS.
- LEND mentors and provides leadership training to prepare staff to have high levels of interdisciplinary competence.
- Within FHSD, there are many potential partner programs serving families including the Neighbor Island DHOs, Women, Infants and Children (WIC), and Children with Special Health Needs Branch (CSHNB). Other Division resources include the ECCS Coordinator and Office of Primary Care and Rural Health.
- The HVP provides quarterly trainings to statewide service providers. MCHB staff and other state agency partners are invited.
- There are numerous programs throughout the State that work with families, staffed by a highly dedicated and knowledgeable workforce.
- Hawaii has access to multiple sources of federal TA and resources for the prevention of child abuse and neglect including MIECHV, CBCAP, Rape Prevention and Education, and Preventive Health and Health Services Block Grants. Title V also partners closely with the DOH Injury Prevention and Control Section, which receives TA from both the CDC and the Child Safety Network.

Challenges, Barriers:

- A fundamental challenge is to improve coordination and collaboration despite funding requirements, program work load, and administrative/procurement rules.
- Statewide training for multi-disciplinary/agencies take staff time and resources, but are essential for developing an effective comprehensive prevention strategy.
- Fragmentation occurs at all levels, starting with different funding streams that promote separate program purposes, reporting, and data collection, even though programs often target the same populations/age groups or overlap with them.

National Performance Measure

NPM-7: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

The 2020 Title V state objective is to decrease the number of hospital admissions for non-fatal injury to 142 per 100,000 children ages 0 through 9 and 179.2 for adolescents 10 through 19. In 2014, the rates of 129.6 for child and 179.2 per 100,000 for adolescents in Hawaii met the objective, and were below the national rate estimates of 146.0 for children and 221.2 for adolescents. The state objective for 2021 was carried over from 2020. Statewide, the rates of hospital admissions for non-fatal injury in both children and adolescents have decreased since 2009 (170.9 for children, 254.6 for adolescents). Higher risk groups could not be reported due to small numbers.

National Outcome Measures

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

The related Healthy People 2020 objective is to reduce the rate of child deaths to 25.7 deaths per 100,000 among 1-4 year olds and 12.3 deaths per 100,000 among 5-9 year olds. In data from 2015, Hawaii met that objective with 14.4 deaths per 100,000 among 1-9 year olds which was lower than the 2015 national estimate of 17.5 deaths per 100,000 among 1-9 year olds. The rate of deaths among 1-9 year olds has decreased in Hawaii since 2009 (19.3 deaths per 100,000).

NOM-16.1: Adolescent Mortality Rate

The related Healthy People 2020 Objectives are to reduce the rate of adolescent deaths age 10 to 14 years to15.2 per 100,000, and to reduce the rate of adolescent deaths age 15 to 19 years to 54.3 per 100,000. In data from 2015, the rate of adolescent deaths was 27.0 in Hawaii which was lower than the national estimate (31.6). There has been no change over time with a rate of 31.5 in 2009. Higher risk groups could not be reported due to small numbers.

NOM-16.2: Adolescent Motor Vehicle Mortality Rate

The Healthy People 2020 Objective is to reduce the rate of adolescent deaths age 15-19 to 12.4 per 100,000. In data from 2013-15, the rate of adolescent deaths age 15-19 was 9.6 in Hawaii which was similar to the national estimate (11.6). There has been no change over time with a rate of 10.8 in 2007-2009. Higher risk groups could not be reported due to small numbers.

NOM-16.3: Adolescent Suicide Rate

The related Healthy People 2020 Objectives are to reduce the suicide to 10.2 per 100,000, and to reduce the rate of suicide attempts by adolescents to 1.7 per 100. In data from 2013-15, the rate of suicide deaths to adolescents age 15-19 was 11.2 in Hawaii which was higher than the national estimate (8.9). There has been no change over time with a rate of 10.8 in 2007-2009. Higher risk groups could not be reported due to small numbers.

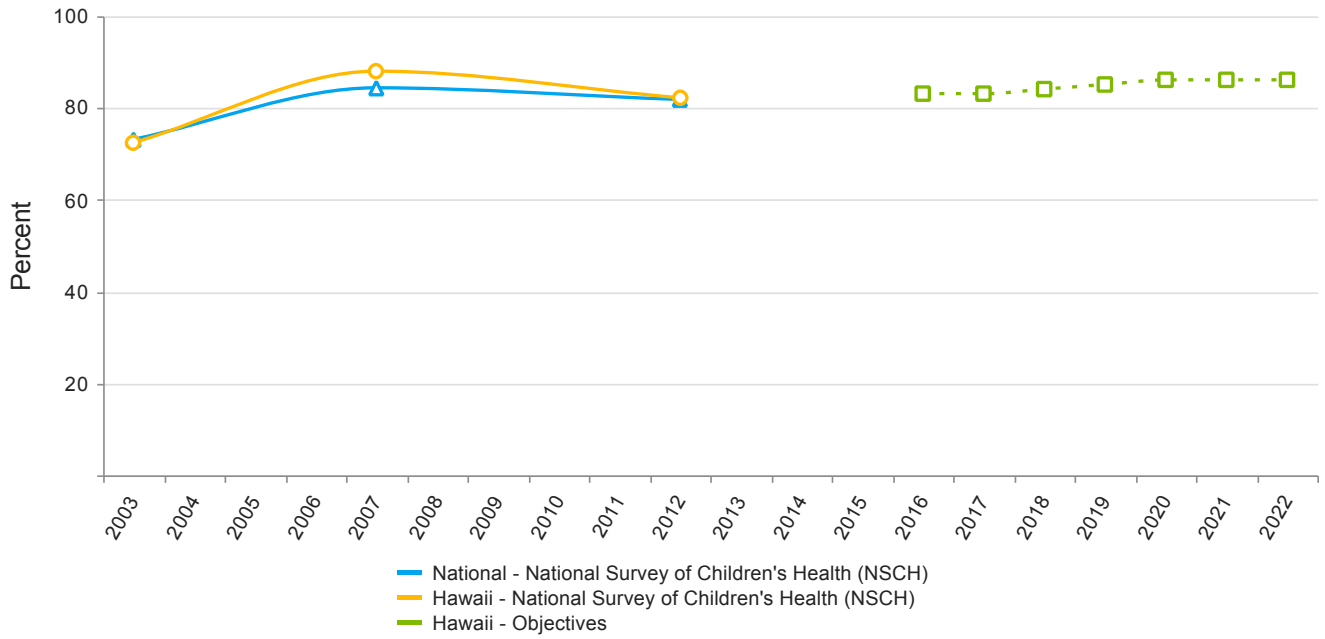
Adolescent Health

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-2015	27.0	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	9.6	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	11.2	NPM 10
NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling	NSCH-2011_2012	58.7 %	NPM 10
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	86.0 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	NSCH-2011_2012	27.4 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	WIC-2014	24.0 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	YRBSS-2015	28.3 %	NPM 10
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	71.8 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	71.3 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	62.6 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	79.6 %	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-2015	78.7 %	NPM 10

National Performance Measures

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	83
Annual Indicator	82.2
Numerator	83,403
Denominator	101,416
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	83.0	84.0	85.0	86.0	86.0	86.0

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:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	
Numerator	13
Denominator	51
Data Source	Art and Science Workgroup
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	15.0	21.0	33.0	42.0	48.0	50.0

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

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 86% (Baseline: 2011-2012 NSCH data 82.2%)

Strategies

Collaboration: Develop partnerships with key community stakeholders to develop strategies to improve utilization of adolescent well care visits.

Family Engagement and Public Awareness: Develop common messaging to describe the value of adolescent well care visit related to prevention and intervention for youth and parents.

Product Development: Disseminate medical home materials including the Adolescent Resource Toolkit (ART) as well as consumer materials on the reasons for and the methods to access adolescent preventive services.

Workforce Development: Increase resources, training and practice improvement support for adolescent health providers to provide teen-centered, well-care visits aligned to Bright Futures.

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	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 with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

NOM 22.2 - Percent of children 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

Adolescent Health - Plan for the Application Year

Priority Need: Adolescent Wellness Visits

The 5-year needs assessment reaffirmed the importance of adolescent well-being as a priority issue. 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. Adolescents with chronic health problems also take on a greater role in managing those conditions. It 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 health visits 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.

The American Academy of Pediatrics Hawaii Chapter adopted improving access to adolescent care as one of its priorities. The Hilopa‘a Family to Family Information Center (F2FHIC) also made adolescent preventive visits a key priority. F2FHIC developed materials and provides education/training to health providers and consumers on adolescent health. Surveys of Hawaii adolescent providers show serious interest in working to improve adolescent access to health care given expanded prevention benefits covered under the Affordable Care Act. In addition, focus groups with pediatric primary care providers demonstrated the need for further skill building and lack of referral resources to address and refer for intervention for risk behaviors and behavioral health. Focus groups with Hawaii youth validate that teens have an alarmingly low awareness of the importance of preventive health care and many do not know their medical home provider.

Data from the National Survey of Child Health (NSCH) 2011-2012 showed that among Hawaii adolescents ages 12 through 17, only 82.2% reported a preventive medical visit in the past year. This is a slight decrease from the previous 2007 survey (87.9%). Overall, Hawaii rate was comparable to the national rate of 81.7%. Given Hawaii’s high level of insurance coverage due to the mandated employer based insurance coverage, it is somewhat surprising the Hawaii rate is not significantly better than the U.S.

Key disparities exist for access to preventive care in Hawaii for adolescents. Rates for non-English speaking, those born outside the U.S. and those residing in rural areas have significantly lower rates. Additionally, Hawaii EPSDT data shows a dramatic decrease of health visits as children reach adolescence.

The 2015 Youth Risk Behavior Survey data showed that 44.3% of middle school aged adolescents and 61.9% of the high school teens saw a doctor for a check-up or preventive physical exam, showing slight declines from the 2013 survey. Kauai County reported the lowest percentages of AWC visits among middle and high school adolescents followed by Maui County and Hawaii County.

Improving access to and receiving preventive services by adolescents means enhancing certain preventive services such as screening, counseling to reduce risk, immunizations and the provision of general health guidance for adolescents. Practitioners can use clinic visits for routine examinations, such as pre-participation athletic evaluations and chronic disease management, to provide other preventive services like early identification of risk behavior and disease, reproductive health assessments, updating immunizations, or offering health guidance.

Priority: Improve the healthy development, health, safety, and well-being of adolescents.

The state priority is based on the Title V National Performance Measures to promote preventive care for adolescents and reflects the interest of key adolescent health partners and Title V programmatic resources that largely focus on teen pregnancy prevention. This is a new priority for Hawaii.

National Performance Measure:

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Transition to Adult Health Care and Establish Medical Homes:

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 transitions to adult care. The national performance measure for transition services addresses both youth with and without special needs. The Title V Adolescent Health Coordinator will coordinate efforts with the CSHN program to address both adolescent health performance measures. (See the Plan narrative for the Children with Special Health Needs Domain for plans to improve transition services for all adolescents).

Objective:

- By July 2020, increase the percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year to 86% (Baseline: 2011-2012 NSCH data 82.2%)

The preliminary 5-year plan objectives were developed using the National Survey of Child Health data for Hawaii as a baseline and projected an almost 5 percent improvement over the next five years.

5-Year Strategies

Recognizing that supporting adolescents is truly an “art and a science,” FHSD seeks to demystify the adolescent well care visit by providing, training, support, and user friendly materials/products to primary care providers to ensure these visits are comprehensive and meet the “Bright Futures” guidelines.

Strategy 1: Collaboration: Develop partnerships with key community stakeholders to develop strategies to improve utilization of adolescent well care visits.

- Work with partners to develop a pilot project or campaign to address the top 2 well-care visit barriers for parents and adolescents.
- Explore clarifying billing mechanisms that support providers to offer a well visit during a visit for a chronic or acute condition.

Strategy 2: Family Engagement and Public Awareness: Develop common messaging to describe the value of adolescent well care visit related to prevention and intervention for youth and parents.

- Convene an Adolescent Health Steering Committee including FHSD/CSHNB/Children with Special Health Needs Program, ART Design Team, youth, and other community partners to develop a survey to determine adolescent and parent views of barriers to annual adolescent preventive care
- Use input from Adolescent Health Steering Committee as well as from the ART & Science Workgroup (ASW) and other partners to provide messaging to providers, youth and families that speaks to the importance of routine adolescent well care.

Strategy 3: Product Development: Disseminate medical home materials including the Adolescent Resource Toolkit (ART) and consumer materials on the reasons for/methods to access adolescent preventive services.

- Convene ART (Adolescent Resource Toolkit) & Science Workgroup including FHSD/CSHNB/Children with Special Health Needs Program, Hilopa‘a Family to Family Health Information Center, Partners in Quality

Health (management service organization (MSO) for leading Independent Physician Association in Hawaii), and American Academy of Pediatrics Medical Home Task Force to work on course content

- Meet with new partners (e.g., specialty providers including inpatient psychiatric hospitals, DOH/Alcohol Drug Abuse Division, DOH/Developmental Disabilities Division) to obtain provider information, and develop referral algorithms
- Compile and document state laws and policies related to adolescent health care including confidentiality, medical record documentation, and consent/assent information
- Develop Hawaii based referral algorithms for behavioral health, substance use, sexual activity, and transition to adulthood
- Disseminate ART to 100 primary care providers serving adolescents

Strategy 4: Workforce Development: Increase resources, training and practice improvement support for adolescent health providers to provide teen-centered, well-care visits aligned to Bright Futures.

- Use input from ART & Science Workgroup to promote "Bright Futures" by developing teen-centered content modules on the following topics: Substance use, behavioral health, sexual activity, transition to adulthood, homelife, healthy eating, and transition across settings, repurposing the sports physical visit, and deliverying teen-centered care
- Deploy "Science" series to primary care providers and their staff using a variety of learning methods
- Consider dissemination of training and ART to jurisdictions and territories
- Establish baseline knowledge and comfort level for addressing adolescent issues with providers
- Assess for increase in knowledge and comfort level post training

Strategy Development

These strategies are derived from Center for Medicare and Medicaid Services (CMS) guidelines for states to increase adolescent preventive health care. The CMS guidelines also complement 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. In addition, strategies were replicated from the past work of FHSD on deploying, *The Rainbow Book, Medical Home Resources Guide for Children with Special Health Care Needs*, a hallmark product of Hawaii services.

Evidence Based/Informed Strategy Measure

The Evidence Based/Informed Strategy Measure (ESM) selected for adolescent wellness is 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." A data collection form was developed to track progress on the measure. This is a summary of the Data Collection Form that lists 17 strategy components:

Adolescent Resource Toolkit (ART)

1. Compile and document state laws and policies related to adolescent health care including confidentiality, medical record documentation, consent/assent information
2. Document Hawaii based case narratives of Bright Futures AWC visits
3. Develop Hawaii based referral algorithms for behavioral health, substance use, sexual activity, and transition to adulthood
4. Acquire resource materials (e.g., posters, brochures, video clips, etc.)

Continuing Education Curriculum Series (Science)

5. Develop behavioral health training module

6. Develop substance use training module
7. Develop sexual activity training module
8. Develop transition to adulthood training module
9. Develop homelife module
10. Develop healthy eating module
11. Develop transition across settings module

Outreach and Training

12. Convene regularly ART & Science Workgroup to conceptualize and refine materials and processes
13. Establish baseline knowledge and comfort level for addressing adolescent issues with providers
14. Disseminate ART to 100 primary care providers serving adolescents
15. Post ART information online
16. Deploy "Science" series to primary care providers and their staff using a variety of learning methods
17. Assess for increase in knowledge and comfort level post 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.

Plans for Application Year Federal Fiscal Year 2018 (10/1/17-9/30/18)

Title V will engage youth groups and families when possible to inform our work as we develop the Adolescent Resource Toolkit (ART), Continuing Education Curriculum Series (Science), and the Outreach and Training for primary care providers. Title V will focus its work over the next year on addressing the continuing education series on sexual activity and transition to adulthood modules while completing the toolkit for the adolescent health providers and the provision of teen-centered well-care visits.

This program year, the Title V Adolescent Health (AH) programs will require contractors to collect baseline data and ask program participants for the name of their health insurance carrier and the name of their physician in an effort to assure adolescents have the information they need to make an appointment. The Title V project team will also continue to explore ways to remove barriers that would prevent adolescents and their families from seeking preventive care visits.

Specific activiities planned for this fiscal year include:

- Re-strategize the implementation plan with the ART & Science Workgroup.
- Assess parent and family awareness regarding adolescent preventive health care and barriers to accessing care to inform strategy development.
- Document complete inventory and clarity confidentiality and consent/assent state laws and in particular DOH and DOE agency policies
- Complete ART sections and training modules for Mental Health, Substance Abuse and Sexual Activity, including referral algorithms and forms, visit materials, community resources and curriculum for "Bright Futures" visit expectations and brief action planning.
- Deploy and evaluate training for primary care on Mental Health, Substance Abuse and Sexual Activity modules

FHSD's Title V team will work on the project activities discussed above. An update on progress will be provided in next year's Title V report. Any needed changes to the 5-Year Plan will be made.

Adolescent Wellness Visits Report

Report on Federal Fiscal Year 2016 (10/1/15 – 9/30/16)

ESM

The FFY 2016 ESM indicator is 13. Using the ESM 10.1 data collection from the ART & Science Workgroup scored progress during this period. The following progress was achieved. The Title V Adolescent Resource Toolkit and Science (ARTS) adolescent workgroup identified primary care providers, health insurance carriers, parents and adolescents as major stakeholders to include in this adolescent well-visit culture shift.

In partnership with the Hilopa'a Family to Family Information Center (F2FHIC) and the DOH Maternal and Child Health Branch (MCH), F2FHIC facilitated physician surveys and MCH LEND held adolescent focus groups to develop preliminary strategies to engage these stakeholders. The ARTS group utilized the general outcomes of the provider survey, adolescent focus groups and adolescent wellness visit (AWV) literature search to develop 17 strategy components to enhance the knowledge and skills of primary care providers needed to address the unique health care needs of adolescents and the implementation of the AWV.

In partnership with Hilopa'a Family to Family Information Center (F2FHIC), bi-monthly informational lunch hour webinars by pediatric specialists were held for providers and their office staff. Polls are sometimes conducted during the interactive presentations and include suggestions as to how to develop rapport with teens or questions asked such as whether sports physicals should be replaced by well-visits.

The AWV ESM was developed and reviewed by Johns Hopkins University staff providing TA for ESM development and by the MCH Bureau staff. Objectives were set to capture progress on this measure on an annual basis. At the August 2016 in-state Title V grant review the ESM received general approval.

Other Activities

In addition to the work on the ESM, a major policy initiative was accomplished that will impact NPM 10. The 2016 Legislature passed Act 185 which will require 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 convened a broad coalition of private-public partners to assure successful implementation such as the Department of Education, the Hawaii Primary Care Association, the Hawaii Medical Services Association, and the American Academy of Pediatrics Hawaii Chapter.

Another approved policy that impacts adolescent wellness is Act 181 which allows adolescent's the right to consent to their own mental health treatment and counseling services. Other age of consent laws pertinent to adolescent preventive visits include: confidentiality of medical records and accessing family planning services and emergency contraception for those 14 years and older.

Report on Federal Fiscal Year 2017 (10/1/16 – present)

ESM

Major work was completed on the ESM Screening, Brief Intervention and Referral to Treatment (SBIRT) project in FFY 2017. The primary care substance use training materials were developed and tested by F2FHIC. The SBIRT can be integrated into an AWV. Pediatricians on Oahu and Hawaii Island received SBIRT training during the first quarter of 2017.

The Title V adolescent health staff attended training on Project Management provided by MCH LEND faculty in

October 2016 to develop detailed work plans to assure progress on the ESM and the 5-year strategies. The work plans can be found in Section V. Supporting documents.

The DOH's Chronic Disease and Health Promotion Division released the first-ever *Hawaii Sexual and Gender Minority Health Report*. The report findings showed heterosexual youth and adults, lesbian, gay, and bisexual (LGB) youth experience greater mental health challenges and are more likely to engage in unhealthy behaviors thereby increasing their risk for chronic diseases and poorer health outcomes. Gender identity and sexual orientation are important issues primary care physicians should address with adolescents. Each year, nearly one in three LGB youth attempt suicide. Educational curriculum materials will include information to help providers engage and support the special needs of LGB youth.

Other Activities

Title V is an active participant in the Hawaii Health Survey committee that provides broad oversight over the administration of the Youth Risk Behavior Survey (YRBS). The 2017 Middle and High School YRBS was administered during the 2017 Spring semester. The question posed to the public middle and high school teens, "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 a dipstick measure of the AWV progress.

The DOE and DOH released the processes to implementing Act 185 in the 2017 to 2018 school year, which requires all youth entering the 7th grade to have a physical examination. Information presentations are being conducted by the DOH Chronic Disease and Health Promotion Division (CDHPD) throughout the state for families and school personnel alike. Students will still be able to attend school if they did not have an AWV and will have the entire school year to get one.

Factor Contributing to Success

Hawaii's Title V teen pregnancy prevention grants provided opportunities through the contractors, to get baseline information such as: Do they have knowledge of who their health insurance carrier is and do they know the name of their personal provider?. Title V partnered with the MCH LEND program to provide ongoing staff development, technical assistance, and convening/facilitation of work plan meetings. In addition, F2FHIC and the Hawaii Pediatric Association Research and Evaluation Foundation (HPAREF), is largely responsible for conducting the bi-monthly webinars for providers that address youth centered issues. MCH LEND provided quarterly working meetings and opportunities. The F2FHIC and HPAREF will remain critical partners to successfully identify and implement activities with the provider community regarding the Affordable Care Act and the impending American Health Care Act.

Challenges, Barriers

Creating a culture shift among health plans, providers, parents, and youth to value and prioritize AWVs is a major challenge to achieve systems change. One of Hawaii's major health insurers is moving into capitated payments to primary care physicians which could present a challenge for providers to schedule and provide a teen-centered AWV. The impending American Health Care Act is expected to create changes in health insurance coverage by no longer mandating health insurance thereby creating an AWV access barrier for adolescents whose families have no health insurance. Securing adequate resources (including dedicated staffing, funding, and leadership) to assure progress for this effort also remains a challenge for FHSD.

National Performance Measure

NPM-10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

The 2020 Title V state objective is to increase the proportion of adolescents, ages 12 through 17, with a preventive

medical visit in the past year to 86.0%. Data from 2011-2012 show that the estimate for Hawaii (82.2%) failed to meet the objective, but exceeded the national estimate of 81.7%. The state objective for 2021 was carried over from 2020 as no data has been available to assess progress for several years. Statewide, there has been a decline from 2007 (87.9%) to the 2011-2012 estimate. Groups at higher risk are adolescents belonging to non-English speaking households (56.1%), non-children with special health care needs (79.2%), and adolescents living in a non-metropolitan statistical area (76.0%). Data from 2016 survey not available at time of reporting.

National Outcomes Measures

NOM-16.1: Adolescent Mortality Rate

The related Healthy People 2020 Objectives are to reduce the rate of adolescent deaths age 10 to 14 years to15.2 per 100,000, and to reduce the rate of adolescent deaths age 15 to 19 years to 54.3 per 100,000. In data from 2015, the rate of adolescent deaths was 27.0 in Hawaii which was lower than the national estimate (31.6). There was no change over time with a rate of 31.5 in 2009. Higher risk groups could not be reported due to small numbers.

NOM-16.2: Adolescent Motor Vehicle Mortality Rate

The Healthy People 2020 Objective is to reduce the rate of adolescent deaths age 15-19 to 12.4 per 100,000. In data from 2013-15, the rate of adolescent deaths age 15-19 was 9.6 in Hawaii which was similar to the national estimate (11.6). There was no change over time with a rate of 10.8 in 2007-2009. Higher risk groups could not be reported due to small numbers.

NOM-16.3: Adolescent Suicide Rate

The related Healthy People 2020 Objectives are to reduce the suicide to 10.2 per 100,000, and to reduce the rate of suicide attempts by adolescents to 1.7 per 100. In data from 2013-15, the rate of suicide deaths to adolescents age 15-19 was 11.2 in Hawaii which was higher than the national estimate (8.9). There was no change over time with a rate of 10.8 in 2007-2009. Higher risk groups could not be reported due to small numbers.

NOM-18: Percent of Children with Mental Health Problems who Receive Treatment.

The related Healthy People 2020 Objective is to increase the proportion of children with mental health problems who receive treatment. In data from 2011-12, the percent of children with a mental/behavioral condition who receive treatment or counseling was 58.7% in Hawaii which was similar to the national estimate (61.6%). There was no change over time with 67.8% in 2003. Higher risk groups could not be reported due to small numbers. Data from 2016 survey not available at time of reporting.

NOM-19: Percent of Children in Excellent or Very Good Health

There are no related Healthy People 2020 Objectives. In data from 2011-12, the percent of children in excellent or very good health was 86.0% in Hawaii which was similar to the national estimate (84.2%). There was no change over time with 86.7% in 2003. Higher risk groups could not be reported due to small numbers. Data from 2016 survey not available at time of reporting.

NOM-20: Percent of children and adolescents who are overweight or obese

The related Healthy People 2020 Objectives are to reduce the proportion of children and adolescents aged 2-19 years who are considered obese to 14.5% and to prevent inappropriate weight gain in youth and adults.

In data from 2011-12, the percent of children 10-17 years of age who are considered overweight or obese was 27.4% in Hawaii which was similar to the national estimate (31.3%). There has been no change over time with 26.9% in 2003. Higher risk groups could not be reported due to small numbers.

In data from 2014, the percent of children 2-4 years of age in WIC who are considered overweight or obese was 24.0% in Hawaii which was lower than the national estimate (30.3%). Higher risk groups could not be reported due to small numbers.

NOM-22.2: Percent of children 6 months to 17 years with seasonal flu vaccine

The Healthy People 2020 Objective is to increase the percentage of children aged 6 months to 17 years who are vaccinated annually against seasonal influenza to 70%. In data from 2015-16, the proportion of children aged 6 months to 17 years vaccinated annually against seasonal influenza was 71.8% which was higher than the national estimate (59.3%) and significantly higher than the estimate in Hawaii in 2014-15 (59.3%). There was no change over time with 67.3% of children getting the recommended seasonal influenza vaccine series in 2009-10. Higher risk groups could not be reported due to small numbers.

NOM-22.3: Percent of adolescents with at least one dose of HPV vaccine

The related Healthy People 2020 Objective is to Increase the vaccination coverage level of 3 doses of human papilloma virus (HPV) for females 13-15 years to 80%. In data from 2015, the percentage of females, age 13-17 years who have received at least one dose of HPV vaccine was 71.3% which is higher than the national estimate (62.8%). There have been no changes over time with 65.0% of getting at least one dose of HPV vaccine in 2009. Higher risk groups could not be reported due to small numbers.

In data from 2015, the percentage of males, age 13-17 years who have received at least one dose of HPV vaccine was 62.6% which is higher than the national estimate (49.8%). There has been improvement over time with 11.7% getting at least one dose of HPV vaccine in 2009. Higher risk groups could not be reported due to small numbers.

NOM-22.4: Percent of adolescents with a Tdap booster vaccine

The related Healthy People 2020 Objective is to Increase the vaccination coverage level of 1 dose of tetanus-diphtheria-acellular pertussis (Tdap) booster vaccine for adolescents by age 13-15 years to 80%. In data from 2015, the percentage of adolescents, age 13-17 years who have received at least one dose of Tdap vaccine was 79.6% which is lower than the national estimate (86.4%). There has been improvement over time with 46.1% of getting at least one dose of Tdap vaccine in 2009. Higher risk groups could not be reported due to small numbers.

NOM-22.5: Percent of adolescents with at least one dose of meningococcal vaccine

The related Healthy People 2020 Objective is to Increase the vaccination coverage level of 1 dose of meningococcal conjugate vaccine for adolescents by age 13-15 years to 80%. In data from 2015, the percentage of adolescents, age 13-17 years who have received at least one dose of meningococcal conjugate vaccine was 78.7% which is similar to the national estimate (81.3%). There has been improvement over time with 51.0% of getting at least one dose of meningococcal conjugate vaccine in 2009. Higher risk groups could not be reported due to small numbers.

Children with Special Health Care Needs

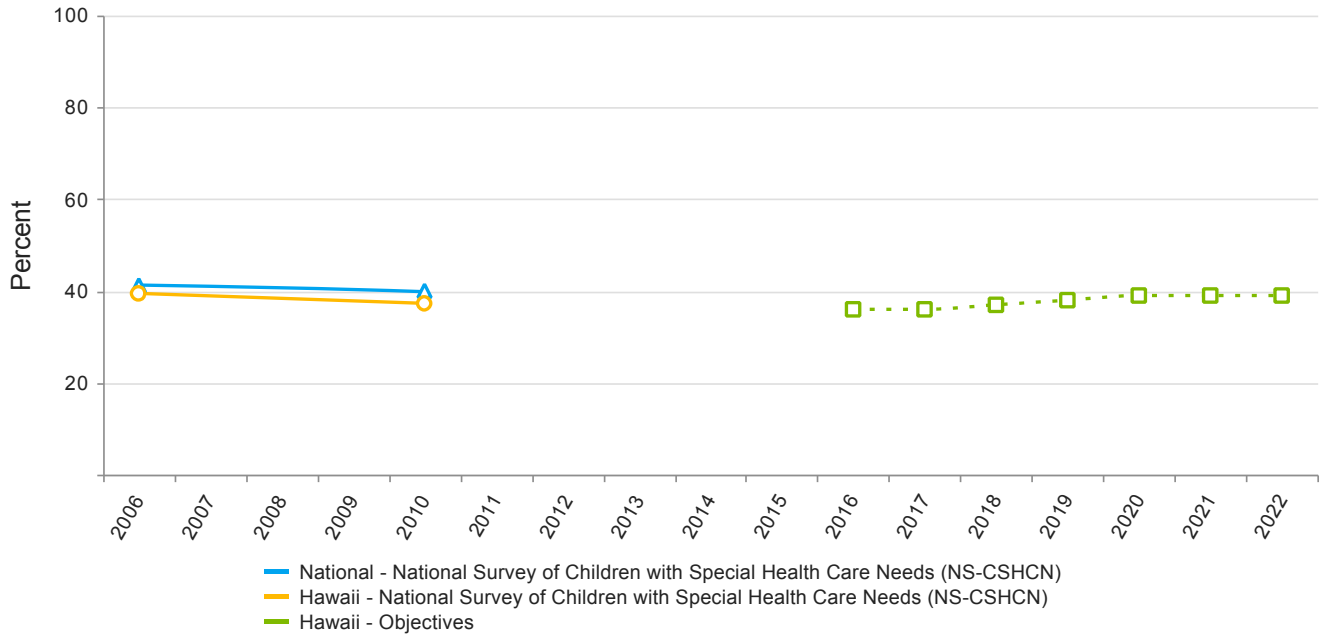
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	NS-CSHCN-2009_2010	22.7 %	NPM 12
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	86.0 %	NPM 12

National Performance Measures

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	36
Annual Indicator	37.3
Numerator	4,714
Denominator	12,643
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	36.0	37.0	38.0	39.0	39.0	39.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - The degree to which the Title V Children and Youth with Special Health Needs Section (CYSHNS) promotes and/or facilitates transition to adult health care for YSHCN.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	
Numerator	4
Denominator	33
Data Source	Title V Transition Workgroup
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	17.0	20.0	23.0	25.0	27.0

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

Percent of adolescents with and without special health care needs 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 40% [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 - The degree to which the Title V Children and Youth with Special Health Needs Section (CYSHNS) promotes and/or facilitates transition to adult health care for YSHCN.	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

Children with Special Health Care Needs - Plan for the Application Year

Priority Need: Services necessary to make transition to adult health care for Youth with Special Health Care Needs (YSHCN) age 12-21 years.

The state priority is based on the Title V block grant guidance National Performance Measure for transitions to adult health care for adolescents with and without special health care needs. In the previous 5-Year project period, transition was identified as a Title V priority, so this is a continuing priority issue for adolescents.

The focus on the transition of children with special health care needs to adult health care is a continuing priority for Hawaii. While the focus on the transition of children without special health care needs to adult health care is a new area for Hawaii, the Children and Youth with Special Health Needs Section (CYSHNS) within the Children with Special Health Needs Branch/DOH understands that the work on transition for youth with special health care needs (YSHCN) also applies to youth without special health care needs.

Transition to adult health care remains an important issue at the national level. In 2011, the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), and American College of Physicians (ACP) jointly published "*Clinical Report – Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home*". In 2015, Federal Partners in Transition Workgroup published "*The 2020 Federal Youth Transition Plan: A Federal Interagency Strategy*", which emphasizes the importance of interagency collaboration and takes an inclusive approach to improve adult outcomes. A Healthy People 2020 Objective (DH-5) focuses on increasing the proportion of youth with special health care needs whose health care provider has discussed transition planning from pediatric to adult health care. The Standards for Systems of Care for Children and Youth with Special Health Care Needs Version 2.0 (June 2017) includes a system domain on Transition to Adulthood, which for the pediatric setting includes Transition Policy, Transition Readiness, Transfer of Care, and Transition Completion.

The five-year needs assessment reaffirmed transition to adult health care as a priority issue in Hawaii:

- 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.
- Hawaii data from the National Survey of Children with Special Health Care Needs (NSCSHCN) 2009/10 showed that the Hawaii rate for transition (37.3%) was lower than the national rate (40.0%). The Hawaii rate for this measure was 39.4% in 2005/6 and 37.3% in 2009/10, but estimates may not be comparable since the survey method added cell phones in 2009/10.
- Professional and state/community agencies and organizations in Hawaii support and are actively working to promote transition to adult life:
  - AAP-Hawaii Chapter 2015 priorities include transition of adolescents to adult care with a focus on youth with special health care needs.
  - Hilopaa Family to Family Health Information Center (F2FHIC) develops materials and provides education and training.
  - Transition events are held throughout the state. Planning involves the CYSHNS, Community Children's Council Office (CCCO), Division of Vocational Rehabilitation (DVR), Developmental Disabilities Division (DDD), Hawaii Maternal Child Health Leadership Education in Neurodevelopmental & Related Disabilities (MCH-LEND), Hawaii State Council on Developmental Disabilities (HIDDC), Hawaii Department of Education (DOE), Hilopaa F2FHIC, Special Parent Information Network (SPIN), and other organizations.
  - The HIDDC 2012-2016 State Plan includes the goal of 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.

The Title V MCH block grant application submitted in July 2017 stated that the priority need was “Improve the percentage of YSHCN age 14-21 years who receive services necessary to make transitions to adult health care.” The CYSHNS is modifying the priority need to age 12-21 years. This was based on a July 2016 “Step Up! Transition to Adult Health Care!” planning meeting that included CYSHNS and Family Health Services Division (FHSD) staff from Oahu and neighbor islands, and two youths with special needs and their parents. The meeting was facilitated by the Hilopaa F2FHIC Director. The query “At what age should Transition begin?” brought a range of answers from 0-17 years. The group acknowledged that that transition planning should begin prior to age 14 years, that skill-building for transition begins during a child’s younger years, and that transition planning may begin around age 12 years based on the individual situation.

National Performance Measure: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care.

Objective: 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 39%. [Baseline: Hawaii 37.3%, NSCSHCN 2009/10]

The 5-year plan objectives were developed using the NSCSHCN data for Hawaii as a baseline and projected a 5 percent improvement over the next five years.

Future data will be from the National Survey of Children's Health (NSCH), sponsored by the MCH Bureau. The NSCH survey was recently redesigned and administered again in 2016. Major changes to the NSCH include a switch from telephone to web-based and paper/pencil survey administration, and new items as a result of combining the NSCH and NSCSHCN. As a result, there may be future changes to the Hawaii Objective for this NPM on transition.

5-Year Strategies

Strategy 1: Incorporate transition planning into CYSHNS service coordination for CYSHNS-enrolled youths and their families.

- Strengthen program infrastructure by establishing standardized procedures and data collection methods.

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.

- Improve/continue collaboration with stakeholders, including YSHCN/families, to develop strategies to improve services for youth and their families necessary to make transition to adult health care.
- Reach out to new stakeholders to raise awareness in the importance of adult health care in transition planning.
- Develop educational materials and disseminate to community.
- Establish training curriculum and pathways for learning about transition to adult health care for youth/families/providers.

Strategy Development

Strategy 1: Incorporate transition planning into CYSHNS service coordination for CYSHNS-enrolled youths

and their families.

The strategy was developed based on the Six Core Elements of Health Care Transition, which 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. The model was developed by the *Got Transition*/Center for Health Care Transition Improvement, based on the joint clinical recommendations from the AAP, AAFP, and ACP.

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 was developed based on recommendations from national reports as well as discussions at the local level. The 2020 Federal Youth Transition Plan and other reports recommend closer collaboration among providers working with transitioning youth. The 2020 Plan also recommends quality professional development for staff engaged in providing services to youth. In 2014, the Centers for Medicare & Medicaid Services (CMS) report on *Paving the Road to Good Health* recommended developing partnerships among key stakeholders and creating adolescent-friendly material.

For this FFY 2018 application, strategies were updated by grouping the FFY 2017 strategies under broader headings to more closely describe and align with current CYSHNS activities. The strategies were grouped by (1) ESM activities to promote and/or facilitate transition to adult health care, which focus on CYSHNS-enrolled children/youth; and (2) education, public awareness, and promoting transition in planning and practices, in collaboration with state and community partners, which focus on all children/youth with and without special health care needs.

Evidence Based/Informed Strategy Measure

The ESM is "The degree to which the Title V Children and Youth with Special Health Needs Section (CYSHNS) promotes and/or facilitates transition to adult health care for YSHCN." The ESM corresponds to the CYSHNS work under Strategy 1. The ESM is focusing on integrating the *Got Transition's* Six *Core Elements of Health Care Transition 2.0* (http://www.gottransition.org/providers/index.cfm) into the Title V CYSHNS service coordination to support CYSHNS-enrolled youth/families in preparing for transition to adult health care.

See Form 10C for the Detail sheet. The Data Collection Form is attached as a Supporting Document in Section V. The Data Collection Form 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, and 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 CYSHNS staff, with input from Hilopaa F2FHIC.

The Data Collection Form item #1 was modified by deleting "including consent/assent information". Item #2 was modified by adding a sentence "Develop the plan for obtaining consent/assent from youth." This change was due to timing and implementation questions that need to be addressed.

Plans for Application Year Federal Fiscal Year 2018 (10/1/17-present)

Strategy 1: Incorporate transition planning into CYSHNS service coordination for CYSHNS-enrolled youths

and their families.

The following are CYSHNS planned activities related to the Data Collection Form for the ESM "The degree to which the Title V CYSHNS promotes and/or facilitates transition to adult health care for YSHCN". The detailed work plan is in Section V, Supporting Documents.

Item	FFY 2018 Plans
Transition policy	
1. Develop a CYSHNS transition policy/statement, with input from youth, families, and providers, that describes the approach to transition.	Develop methods to inform youth/family/public on the policy. Post the policy on the CSHNB website.
2. Educate all staff about the approach to transition, the 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. Develop the plan for obtaining consent/assent from youth.	Continue studying current practice to identify how CYSHNS may change the approach so that transition is a familiar and friendly concept. Continue the process of educating staff. Continue developing CYSHNS procedures, including obtaining consent/assent from youth.
Transition tracking and monitoring	
3. Establish criteria and process for identifying and tracking transitioning youth in the CYSHNS database.	Establish the CYSHNS process for staff to input and track transitioning youth in the CYSHNS database. Explore the possibility of the Access data system sending alerts to staff of youth approaching age 12 years or when a transition update is due.
4. Utilize individual flow sheet or database to track youth's transition progress.	Work with database developer to incorporate the flow sheet into the Access database so that staff can track and monitor transition progress. Develop a community event form for the clinics, fairs, forums, etc., in which CYSHNS staff have a role in providing transition and other information.
Transition readiness	
5. At least annually assess transition readiness with youth and parent/caregiver, beginning at age 14, to identify needs related to the youth managing his/her health care (self-care).	Finalize pre-transition handout for children under age 12 years and accompanying talking points. Finalize Transition Readiness Assessment form and accompanying talking points. Establish how and when the pre-transition handout and Transition Readiness Assessment form will be used.
6. Jointly develop goals and prioritized actions with youth and parent/caregiver, and document in a plan of care.	Work toward consensus on a standardized tool for developing and documenting goals and action in a person-centered plan of care. Obtain feedback from youths/families and review various planning tools.
Transition planning	
7. At least annually update the plan of care, in	Examine whether Transition Readiness Assessment form and the

Item	FFY 2018 Plans
partnership with youth and families, including readiness assessment findings, goals, and prioritized actions.	pre-transition handout may also be used in the planning process.
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.	Develop talking points for discussion with youth about legal changes in decision-making, privacy, consent, and self-advocacy.
9. Develop and implement referral procedures to adult service agencies.	Continue participation in the NWD network of agencies working to streamline the process of making and receiving referrals for long-term care services. The vision for the network is to develop into a coordinated, integrated, and person-centered system of long-term services and supports for individuals of all ages, all disabilities and all payers.
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.	Continue work toward effectively helping families prepare for adult health care, using the tools and procedures that are being developed.
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.	Develop procedures to confirm completion or ensure that further guidance is given, if needed.

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.

CYSHNS will continue involvement in transition education events for youth and their families, including the *Big MAC/M and M Fairs*, SPIN Conference, Malama da Mind, legislative forums, Marshallese Day, Healthy From Head to Toe, You Can't Have Inclusion Without Us, Parent Child Fair, Keiki Steps, GrandCares, etc.

CYSHNS will continue participation on the Oahu *Footsteps to Transition Fair* planning committee's monthly meetings. The next Fair will be held on 10/21/17 at Windward Community College (WCC) with Windward DOE co-hosting the event. WCC is a great venue–well known, accessible, ample parking, and lots of space for display tables. It is hoped that this encourages other colleges to send their recruiters to the Fair, since families have requested more information on colleges and technical schools. Honolulu Community College has been participating ever since the former *Footsteps to Transition Fair* Co-chair became their disability specialist.

CYSHNS will continue its collaboration in other transition-related activities of the State Traumatic Brain Injury Advisory Board (STBIAB), HIDDC's Education/Training/Public Awareness sub-committee, DDD's CoP, ADRC's NWD, Transition Fair workgroups, and the CDFH FASD conference planning.

Transition to Adult Health Care Report

Report on Federal Fiscal Year 2016 (10/1/15 – 9/30/16)

For FFY 2016 the degree to which the Title V Children and Youth with Special Health Needs Section (CYSHNS) promotes and/or facilitates transition to adult health care for YSHCN (ESM 12.1) is measured at 4 out of 33.

Strategy 1: Incorporate transition planning into CYSHNS service coordination for CYSHNS-enrolled youths and their families.

The following are CYSHNS activities related to the Data Collection Form for the ESM "The degree to which the Title V CYSHNS promotes and/or facilitates transition to adult health care for YSHCN":

Item	FFY 2016 Activities	*Status*
Transition tracking and monitoring		
4. Utilize individual flow sheet or database to track youth's transition progress.	CYSHNS staff discussion on items to be tracked resulted in a data collection form (Excel spreadsheet) drafted by the Hilopaa F2FHIC Director.	Partially met (1)
Transition readiness		
6. Jointly develop goals and prioritized actions with youth & parent/caregiver, & document in a plan of care.	CYSHNS staff are currently developing goals, actions, and a plan of care with their youth and families.	Partially met (1)
Transition planning		
8. Prepare youth & 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.	CYSHNS staff are currently discussing transition to adult health care with their youth and families, with a focus on adult health care providers and health insurance.	Partially met (1)
Transition transfer of care		
10. Prepare youth & parent/caregiver for transferring to an adult health care provider and planning for health insurance coverage as an adult.	CYSHNS staff are currently preparing youth and their parent/caregivers for adult health care providers (especially specialty care) and health insurance.	Partially met (1)
	Score (baseline)	4

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.

CYSHNS staff collaborated with partners in planning educational activities throughout the year across the state. These included:

- Maui held the *Big Moving Across Communities* (MAC) and *Moving Across Middle* (M and M) Transition Fairs.
- CYSHNS helped plan and provided transition information at fairs, legislative forums, Marshallese Day, Healthy From Head to Toe, Parent Child Fair, Malama da Mind, and Keiki Steps.
- CYSHNS convened Oahu's *Footsteps to Transition* Fair at Kapolei High School on 10/24/15. The Transition Fair included a presentation on transition to adult life by the Hilopaa F2FHIC Director and a panel of local

youth with special needs. The Fair was co-sponsored by DOE Central/Leeward District, Hilopaa F2FHIC, MCH-LEND, SPIN, HIDDC, the Arc, DDD, CCCO, and Best Buddies Hawaii. The Fair alternates among DOE districts each year, giving families the chance to participate in their own community. The Fair is open to the public. Due to cancellation of the 2014 Central Transition Fair on the day before the event in anticipation of Hurricane Ana, the Leeward representatives had transitioned into the Fair planning team and agreed to a joint Central/Leeward Fair for 2015. It required compromise in location, but doubled the available staff and funding resources and the field of participants.

ESM Development

Much of the FFY 2016 activities focused on the Title V five-year plan for transition to adult health care, including: researching transition-related strategies that are evidence-based/informed, developing consensus on the proposed CYSHNS strategy, developing consensus on proposed CYSHNS activities, developing the data collection form, and obtaining technical assistance on the ESM and activities.

Report on Federal Fiscal Year 2017 (10/1/16 – present)

Strategy 1: Incorporate transition planning into CYSHNS service coordination for CYSHNS-enrolled youths and their families.

The following are CYSHNS current activities related to the ESM Data Collection Form:

Item	FFY 2017 Activities
Transition policy	
1. Develop a CYSHNS transition policy/statement, with input from youth, families, and providers, that describes the approach to transition.	CYSHNS developed a Policy Statement for the Transition to Adult Health Care, approved on 3/2/17, that states: "We will listen to children and youth with special health needs, to help guide them and their families over time by: • Teaching them about their bodies and how to develop good health habits, and • Supporting them by sharing the knowledge and skills needed for a successful adult life using adult health care. We will share information about health care and other services through community partnerships and events."
2. Educate all staff about the approach to transition, the 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. Develop the plan for obtaining consent/assent from youth.	CYSHNS staff have been informed about and participated in considering the CYSHNS approach to transition, transition policy, consent/assent, and roles in the transition process. A "Step Up! Transition to Adult Health Care 2!" planning meeting was held on 6/6/17 with CYSHNS and FHSD staff from Hawaii Island, Kauai, and Oahu; Hilopaa F2FHIC; and a neighbor island youth and her parent. The meeting facilitated identifying touchpoints in time with youth/families where consent/assent can be obtained. The meeting was facilitated by the Hilopaa F2FHIC Director.
Transition tracking and monitoring	
3. Establish criteria and process for identifying and tracking transitioning youth in the CYSHNS database.	Criteria for tracking youth were established: For age 0-12 years, track health-related habits, knowledge, and skills. For age 12-21, track transition planning, assessment, and goals. For age 18-21 years, track adult health care provider and health insurance. At discharge from CYSHNS services, track future health

Item	FFY 2017 Activities
	care services.
4. Utilize individual flow sheet or database to track youth's transition progress.	A draft data collection form (Excel spreadsheet) was tested and revised based on feedback by CYSHNS staff on Oahu and neighbor islands. This flow sheet is now ready for incorporation into the CYSHNS database.
Transition readiness	
5. At least annually assess transition readiness with youth and parent/caregiver, beginning at age 14, to identify needs related to the youth managing his/her health care (self-care).	Sub-committee work and youth/family feedback resulted in: • A pre-transition handout for children under age 12 years (draft). The handout promotes responsibility and self-advocacy in health care in areas of Taking Care of Myself, Nutrition, Knowing About Your Health, Friends and Activities, Safety. • A Transition Readiness Assessment form (third draft).
6. Jointly develop goals and prioritized actions with youth and parent/caregiver, and document in a plan of care.	CYSHNS staff are currently developing goals, actions, and a plan a care with their youth and families using the existing Family and Individual Plan. CYSHNS staff are participating with the DOH DDD Community of Practice (CoP) meetings and trainings on the Fundamentals of LifeCourse Framework. CYSHNS staff are exploring how it may be incorporated into practice.
Transition planning	
7. At least annually, update the plan of care, in partnership with youth and families, including readiness assessment findings, goals, and prioritized actions.	Discussions on current practice and improvement have included developing or collecting talking points to assist staff to better engage youth/family in the planning process, and incorporating the assessment tool and pre-transition age flyer into the discussion with families.
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.	CYSHNS staff discuss transition to adult health care with their youth and families, focusing on adult health care providers, health insurance, and personal responsibility. Staff discuss transition at Kapiolani Cleft and Craniofacial Clinics, Hawaii Community Genetics Clinic, and neighbor island cardiac/neurology/nutrition clinics.
9. Develop and implement referral procedures to adult service agencies.	CYSHNS is participating in the No Wrong Door (NWD) statewide initiative (led by the Executive Office of Aging/ Aging and Disability Resource Center [ADRC]) to make it easier to access long-term services and supports for individuals with disabilities and chronic conditions. CYSHNS staff are participating in the NWD referral tool pilot which includes an electronic referral process.
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.	Work is underway to study current practices and develop a standardized, improved approach to transition planning.
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.	CYSHNS staff have discussed contacting the youth and parent/caregivers at discharge to discuss adult health care providers and health insurance, and how to do this in a feasible way.

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.

CYSHNS continues multiple collaborations with stakeholders, including youth and family members. The Honolulu District Footsteps to Transition Fair was held on 10/22/16 at Kaimuki High School. The Hilopaa F2FHIC Director and a panel of local youth with special needs provided presentations on transition to adult life to youths, families, and state/community agencies. Agencies participated in providing information about their services.

CYSHNS provided a presentation on "Support for Children & Youth Transitioning to Adult Health Care" at a 3/7/17 meeting sponsored by the Med-QUEST Division (State Medicaid agency)/Department of Human Services. The meeting was for QUEST Integration health plans/mid-level managers to be more aware of current supports for children transitioning to adulthood.

CYSHNS staff attended the Coalition for a Drug-free Hawaii (CDFH) presentation on "Fetal Alcohol Spectrum Disorder (FASD) and Transition Planning to Adulthood", and is participating in the conference planning.

Factors Contributing to Success

Factors contributing to success for Strategy 1:

- The evidence-informed Six Core Elements of Health Care Transition, developed by Got Transition and adapted for CYSHNS activities, was very helpful in identifying key components and steps for CYSHNS to address.
- The Hilopaa F2FHIC Director was instrumental in bringing the family perspective to the Title V transition work. The Hilopaa F2FHIC Director assisted in facilitating, supporting, and guiding the work of the CYSHNS staff. The Hilopaa F2FHIC Director also assisted in supporting youth with special needs and their families in attending CYSHNS planning meetings and providing their input into CYSHNS planning.
- Transition to adult health care is a topic of interest to CYSHNS staff (Title V workgroup on Transition to Adult Health Care). Staff are actively involved in planning and developing program changes.
- The Hawaii MCH LEND sponsored trainings on project management, communication, facilitation, mediation, behavioral change techniques, effective powerpoint, etc., with the focus on skill development for leadership, collaboration, and planning/implementation. Their consultation and facilitation assistance is invaluable to the CYSHNS staff.

Factors contributing to success for Strategy 2:

- Many state and community partners are interested in transition to adult life. This is evident in the many partners collaborating in planning and convening the Transition Fairs.
- The *2020 Federal Youth Transition Plan: A Federal Interagency Strategy* encourages interagency collaboration to improve transition services to youth with and without disabilities.
- Excellent evidence-based resources are on the internet such as the *Got Transition* website and Missouri's Family to Family LifeCourse framework. Local online resources for youth and families include the Hilopaa F2FHIC Transition Workbook, Personal Health Record, provider checklists, and CYSHNS's transition flyer.
- High school students in public education are required to make personal transition plans. Hawaii's DOE has been hosting transition fairs for youth and their families with special needs—agency representatives (with partners including CYSHNS) begin planning a year in advance.
- DDD's CoP and ADRC's NWD projects will enable CYSHNS to serve people across the lifespan. These projects encourage collaboration among agencies, person-centeredness, and use of a lifecourse philosophy.

The Hilopaa F2FHIC Director linked CYSHNS to these two projects.

- Title V Leadership provides professional development and support via monthly trainings/technical assistance.

Challenges, Barriers

Challenges for Strategy 1:

- The availability of time for CYSHNS staff to address transition is sometimes a challenge, since CYSHN staff are involved in other activities and initiatives.
- CYSHNS staff with high caseloads are challenged in having the time to engage families whose primary interest may be the CYSHNS financial assistance with pediatric specialty services.
- Working with youth and their families on transition is sometimes challenging for staff. Families and youths are busy and some may lack the time, resources, support, and energy to tackle transition issues.
- Sometimes there are no adult resources available for referrals as youth transition to adult life. For example, Medicaid dental coverage does not provide preventive care or basic restorative treatment for adults.

Challenges for Strategy 2:

- Providers and agencies involved in transitioning youth have not coordinated their efforts. For example, youths may have transition plans through their school that do not include transition to adult health care. Transition forms may differ and have different focuses.
- Providers and agencies have other focuses (for example, mental health, substance use, etc.) in working with youth/adults with and without special needs, and have less attention on transition of youth to adult health care.

National Performance Measure

NPM-12: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

The 2020 Title V state objective is to increase the proportion of adolescents with and without special health care needs who received services necessary to make transitions to adult health care to 39.0%. Data from 2009-2010 show that the estimate for Hawaii (37.3%) failed to meet the objective, and was also below the national estimate of 40.0%. The state objective for 2021 was carried over from 2020 as no data has been available to assess progress for several years. The proportion of youth with and without special health care needs who received services necessary to make transitions to adult health care to have decreased since 2005-2006 (39.4%). Higher risk groups could not be reported due to small numbers. Data from 2016 survey not available at time of reporting.

National Outcome Measures

NOM 17.2: Percent of children with Special Health Care Needs receiving care in a well-functioning system.

The related Healthy People 2020 Objectives are to increase the proportion of children who have access to a medical home to 63.3%, increase the proportion of children with special health care needs who have access to a medical home 54.8%, and increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems for children aged to 22.4% and for children aged 12 through 17 to 15.2%. In data from 2009-10, the proportion of children with special health care needs (CSHCN) receiving care in a well-functioning system in Hawaii was 22.7%, which was greater than the national estimate of 17.6%. Higher risk groups included children from women who were unmarried (10.1%) and children with Medicaid (13.2%). Data from 2016 survey not available at time of reporting.

NOM-19: Percent of Children in Excellent or Very Good Health

There are no related Healthy People 2020 Objectives. In data from 2011-12, the percent of children in excellent or very good health was 86.0% in Hawaii which was similar to the national estimate (84.2%). There has been no change over time with 86.7% in 2003. Higher risk groups could not be reported due to small numbers. Data from 2016 survey not available at time of reporting.

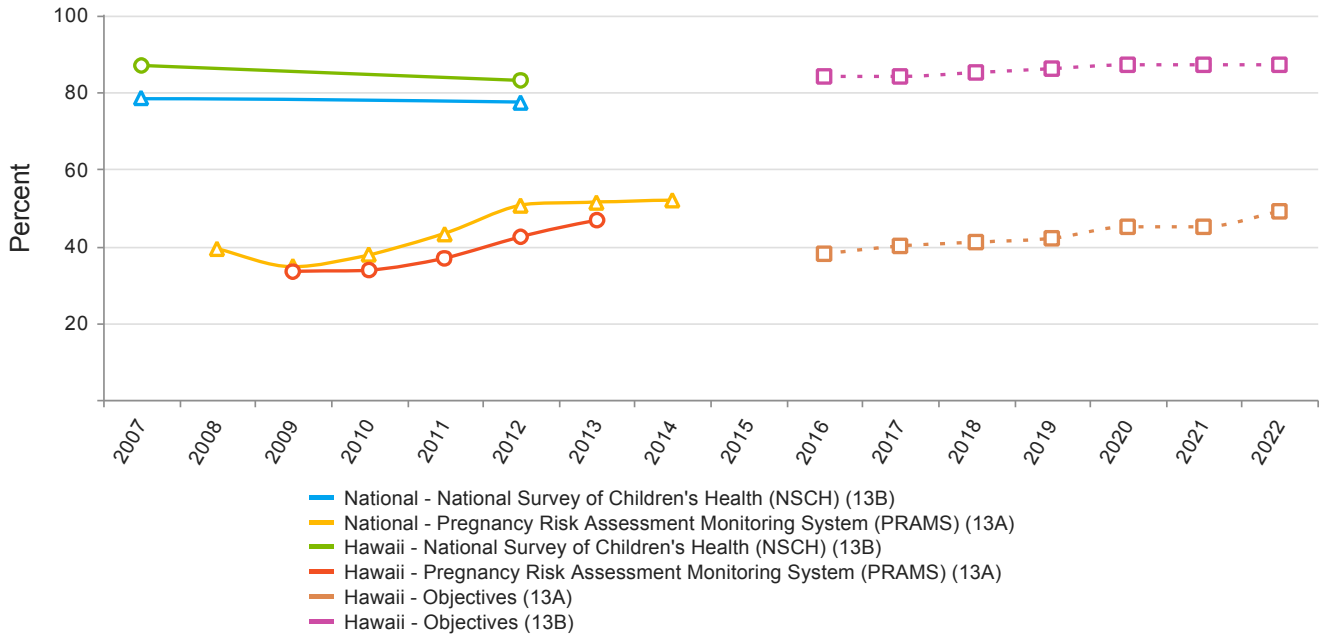
Cross-Cutting/Life Course

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months	NSCH-2011_2012	19.6 %	NPM 13
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	86.0 %	NPM 13

National Performance Measures

NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year
Baseline Indicators and Annual Objectives



NPM 13 - A) Percent of women who had a dental visit during pregnancy

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	38
Annual Indicator	46.8
Numerator	8,607
Denominator	18,380
Data Source	PRAMS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	40.0	41.0	42.0	45.0	45.0	49.0

NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	84
Annual Indicator	83.1
Numerator	236,960
Denominator	285,187
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	84.0	85.0	86.0	87.0	87.0	87.0

Evidence-Based or –Informed Strategy Measures

ESM 13.1 - The establishment of leadership for the State Oral Health Program under the direction of a dental professional and staff with public health skills.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	State Oral Health Program, Family Health Svcs Div
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 13.2 - Completion of teledentistry pilot project at three early childhood settings to reach underserved children and pregnant women.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Virtual Dental Home Planning Team
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

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
Annual Objective	
Annual Indicator	
Numerator	8
Denominator	72
Data Source	Telehealth work group, FHSD
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	22.0	34.0	44.0	56.0	68.0	72.0

SPM 2 - The percentage of Family Health Services Division (FHSD) staff that have increased their knowledge on family/consumer engagement.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	23.9
Numerator	11
Denominator	46
Data Source	FHSD Staff Survey
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	29.0	34.0	39.0	44.0	49.0	54.0

SPM 3 - The percentage of Family Health Services Division (FHSD) staff that have increased their knowledge on Partner Engagement.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	13
Numerator	6
Denominator	46
Data Source	FHSD Staff survey
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	18.0	23.0	28.0	33.0	38.0	43.0

State Action Plan Table

State Action Plan Table (Hawaii) - Cross-Cutting/Life Course - Entry 1

Priority Need

Improve the oral health of children and pregnant women.

NPM

A) Percent of women who had a dental visit during pregnancy and B) 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 87% (Baseline: 2011-2012 NSCH data 83.1%)

By July 2020, increase the percent of women who had a dental cleaning during pregnancy to 39% (Baseline: 2011 PRAMS data 37%)

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 13.1 - The establishment of leadership for the State Oral Health Program under the direction of a dental professional and staff with public health skills.	Active
ESM 13.2 - Completion of teledentistry pilot project at three early childhood settings to reach underserved children and pregnant women.	Active

NOMs

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (Hawaii) - Cross-Cutting/Life Course - Entry 2

Priority Need

Improve access to services through telehealth

SPM

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.

State Action Plan Table (Hawaii) - Cross-Cutting/Life Course - Entry 3

Priority Need

Improve family and consumer engagement in Title V Programs.

SPM

The percentage of Family Health Services Division (FHSD) staff that have increased their knowledge on family/consumer engagement.

Objectives

By July 2020, increase the engagement of families and consumers in Family Health Services Division (FHSD) activities.

Strategies

• Work Together in Collaboration: - Identify priority focusing on Family and Consumer Engagement. - Convene agency and community stakeholders to develop strategies to increase family and consumer engagement in FHSD activities. Include families and consumers (youth) in the planning process. - Conduct inventory of programs where family and consumer engagement is being used. - Identify target programs that need family/consumer engagement. - Initiate Plan Do Study Act (PDSA) cycle for early adopters to evaluate engagement opportunities and process refinement. - Develop FHSD engagement guideline for use by all Title V Priority Areas.

• Provide Awareness and Education: - Develop educational materials to promote family engagement. - Provide opportunities for dissemination of educational materials promoting family engagement.

• Encourage Staff development: - Provide annual self-assessment to staff to determine their knowledge on family/consumer engagement. - Provide opportunities for staff to discuss family and consumer engagement. - Develop collateral materials for staff to use for family and consumer engagement.

State Action Plan Table (Hawaii) - Cross-Cutting/Life Course - Entry 4

Priority Need

Improve partner engagement in Family Health Services Division (FHSD).

SPM

The percentage of Family Health Services Division (FHSD) staff that have increased their knowledge on Partner Engagement.

Objectives

By July 2020, increase meaningful partnerships with FHSD Programs

Strategies

• Determine and Evaluate Outcomes of Meaningful Partnerships o Determine indicators and benchmarks of Meaningful Partnerships o Determine data collection needs and sources

• Work with Partners to Identify Best Practices o Convene partners to determine willingness to engage in the process of Meaningful Partnerships o Conduct Partner Assessment of FHSD Partner Engagement o Meet with partners to study and address successes, barriers, challenges

• Engage Staff to Support Meaningful Partnerships o Determine definition of meaningful partnerships o Develop self-assessment tool to measure partnerships o Identify programs to conduct Plan Do Study Act (PDSA) on Meaningful Partnerships

Cross-Cutting/Life Course - Plan for the Application Year

Priority Need: Improve the oral health of children and pregnant women

The state priority is based on the Title V block grant guidance National Performance Measures for oral health which focuses on both children and pregnant women. In the previous 5-Year project period oral health for children was identified as a Title V priority, so this is a continuing priority issue for children. The focus on oral health of pregnant women is a new priority for Hawaii.

The five-year needs assessment reaffirmed the importance of oral health for adults and children as a priority issue. Oral health was identified in several statewide assessments and reports including the State Hospital Association and the state Health Transformation Office which both conducted extensive stakeholder surveys and community meetings to identify statewide health concerns. In 2015 the Pew Charitable Trusts confirmed oral health as an important issue for Hawaii giving the state its fifth consecutive “F” grade on children’s oral health in the U.S. While not mandated, the Hawaii State Department of Health (DOH) does have statutory responsibility for assessing state dental needs and resources, providing services, conducting education and training, applying for federal funds, as well as planning.

Many of Hawaii’s children and adults suffer from dental disease. Although data from population based surveys indicate Hawaii rates of oral health status and service utilization are similar to the rest of the U.S., the uninsured, low-income, those with Medicaid coverage, and Native Hawaiian/Pacific Islanders suffer disproportionately in the state.

Although, Hawaii has a favorable ratio of dentists to residents; most of the State’s primary and specialty care providers are located on the island of Oahu (Honolulu County). Like many states, Hawaii also has a shortage of providers willing to treat Medicaid clients. The situation is particularly acute on the rural neighbor islands and in low income urban/rural areas of Oahu.

A major contributor to the problem of dental disease is the lack of community water fluoridation. In The U.S., Hawaii has the lowest proportion of residents with access to the benefits of fluoridated drinking water. Only Hawaii federal military bases have fluoridated drinking water.

While Hawaii has many dedicated oral health stakeholders and community based programs, a major problem is the lack of oral health infrastructure and a coordinated system of care. In 2009, the DOHDental Health program was eliminated due to budget restrictions as a result of the state and national recession. DOH continues to operate several dental clinics on Oahu under the Division of Developmental Disabilities (DDD), since this is the primary population served. In 2012 oral health planning and surveillance responsibilities were assigned to Family Health Services Division (FHSD). FHSD has no dental health professionals on staff; thus, works closely with the DDD Branch Chief who is a dentist. Unlike other states, Hawaii has no local health departments, thus DOH is key in providing statewide leadership for critical public health surveillance, evaluation, planning and prevention functions. Without a dental school, DOH can also play an important role to promote evidence based dentistry in both public and private settings by supporting workforce training and research.

National Performance Measures:

A. Percent of women who had a dental visit during pregnancy, and
B. 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 87% (Baseline: 2011-2012 NSCH data 83.1%)
- By July 2020, increase the percent of women who had a dental cleaning during pregnancy to 39% (Baseline: 2011 PRAMS data 37%)

The 5-year plan objectives were developed using data from the National Survey of Children's Health and the Pregnancy Risk Assessment Monitoring System (PRAMS) as a baseline and projecting a five percent improvement through 2020.

5-Year 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

Strategy Development

The five strategies are taken from the FHSD 5-Year Centers for Disease Control (CDC) oral health state infrastructure building grant. The infrastructure grants are provided to build public health capacity to reduce the prevalence of oral health disease in the population and establish a state oral health program (SOHP).

Evidence Based/Informed Strategy Measure

There are two Evidence Based/Informed Strategy Measures (ESM) selected for oral health. The first measure (ESM 13.1) focuses on one of the key strategies for building the oral health infrastructure for the DOH - assuring the program has qualified leadership, a dental professional and staff with public health skills. Although FHSD has made substantial progress leveraging the resources from its CDC grant, progress on filling the SOHP positions has been challenging. Thus, this strategy was prioritized for Title V since effective programs could not proceed without dedicated dental leadership and staffing.

The ESM measure is "The establishment of leadership for the State Oral Health Program under the direction of a dental professional and staff with public health skills." The measure is tracked by a 'Yes' or 'No'. 'Yes' refers to the completion of the 6 steps to assure leadership is provided for the SOHP. No indicates the steps are still in progress. See Form 10C for the Detail sheet.

The second ESM 13.2 focuses on the completion of a pilot demonstration project for teledentistry. The project is planned to be conducted at three early childhood program sites and may also extend services to pregnant women (the latter is yet to be determined). Teledentistry helps reach and provide diagnostic and preventive dental services for underserved populations that traditionally do not get dental care until they have advanced disease, pain, and infection. Oftentimes, accessibility to preventive services is more readily available when provided by hygienists in a public health setting. Through this model of care, dentists are not required to leave the clinic setting but instead 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 in a low-cost setting. With the use of radiographs and photographs, dentists can diagnose conditions remotely while children receive preventive services in a timely manner. Diagnosis through teledentistry also affords the opportunity to refer patients in a timely manner and reduces the costs associated with the high cost dental operatories.

The ESM was selected to provide information on DOH oral partnership efforts and that reflect efforts to pilot innovative programs to improve access to care for young children and possibly pregnant women. This measure also

supports one of Hawaii's State Performance Measures to promote telehealth in Title V programs.

The actual measure is "Completion of a teledentistry pilot project at three early childhood settings to reach underserved children and pregnant women." The measure is tracked by a 'Yes' or 'No'. 'Yes' refers to the completion of the 16 project activities. No indicates the project is still in progress. See Form 10C for the Detail sheet.

Plans for Application Year Federal Fiscal Year 2018 (10/1/17-9/30/18)

ESM Plans

- Conduct leadership orientation and mentoring for the Dental Director through ASTDD.
- Continue recruitment/hiring for Oral Health Program Manager to assure state public health leadership for the state oral health program.
- Continue teledentistry pilot project at two early childhood sites. A second pilot site on Maui is currently seeking funding.

Other Oral Health Strategies

- Implement a Head Start/Early Head Start Oral Health Basic Screening Survey. Plans include mobilizing community resources to assure Head Start children access oral health services for this underserved population.
- Publish findings of the pilot school dental sealant project (evidence based strategy) to identify cost-effective, sustainable service delivery/financing models.
- Publish oral health environmental scan study
- Convene steering committee to develop process for state oral health strategic planning
- Promote coalition-building, partnerships to assure a diverse/broad participation in efforts state oral health planning.
- Development of preliminary oral health communications plan
- Apply for additional 5-year CDC oral health infrastructure funding when announcement is released.

FHSD will continue to work on the current administrative and project activities discussed above. It will also continue to support partnership development and coalition building to assist with development and implementation of state oral health strategic planning. To help inform the planning process, FHSD is currently working with a consultant to perform an environmental scan and policy review. An update on progress will be provided in next year's Title V report. Any needed changes to the 5-Year Plan and its strategy measures will be identified and revised.

Priority Need: Telehealth

Expanded use of telehealth technology was identified as a priority in the Title V 5-year needs assessment. 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 (17.3%) compared with non-CSHCN (3.3%). (Data source: NSCH 2011/12). The 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. 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 is a rise in the statewide efforts towards increasing 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 met several times with Department of Health, University of Hawaii, and hospital representatives to discuss ways to increase the use of telehealth in Hawaii. In 2014 the Legislature passed Act 159 for face-to-face and telehealth reimbursement parity.

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. DOH is also funded by the Association of State and Territorial Health Officers for a joint project with Alaska to explore successful telehealth activities. 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), 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 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.

Priority: Increase the use of telehealth across Title V activities 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.

5-Year Strategies

Strategies for expansion of telehealth in Title V programs are:

- Telehealth infrastructure development
  - 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.

Strategy Development

The strategies were developed by the FHSD staff, led by the Genomics Section supervisor who serves as the FHSD lead for this priority.

State Performance Measure 1

The State Performance Measure (SPM) 1 is "The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers." 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.

Plans for Federal Fiscal Year 2018 (10/1/17-9/30/18)

The objectives for SPM 1 were set based on anticipated completion of activities based on the work plan timetable. The Title V online telehealth training modules will be implemented during FFY 2018 as part of the Title V training for staff and contracted providers. This training will also include hands-on training in partnership with the Pacific Basin Telehealth Resource Center. The training will include on-going evaluation of how telehealth is being used by the trainees.

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 2017, Title V activities 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.

Priority Need: Improve family and consumer engagement

Hawaii's Title V program, in alignment with the priorities of the federal Title V MCH Bureau, values the involvement of families and consumers in the work to reduce disparities and advance positive outcomes at all stages of the life course. Consumers provide critical and unique perspectives, necessary to inform the development of policies and systems, quality assurance and improvement, and ensures that the work of Title V programs remain responsive to the emerging needs of the children and families it serves.

A theme of family and consumer engagement ran through the five-year needs assessment as each of the priority areas discussed the need for recognizing and supporting family and consumer involvement. Although efforts to

engage family/consumer/youth input were substantially improved over the previous Title V needs assessment; there is recognition that more could be done to build agency wide infrastructure to support greater input and engagement. Thus, family and consumer engagement was identified as a priority in the five-year FHSD needs assessment.

This graphic was used by FHSD to help staff conceptualize levels of family/consumer engagement.

State Performance Measure 2

The SPM 2 is a measurement of key FHSD program staff knowledge, attitudes, and skill level on engaging these families and consumers. The data will be collected and measured annually through web-based survey tools. Staff will be asked to rate their level of knowledge of Family/Consumer engagement as:

- Expert ("I know the topic quite well and am confident talking to families or others about it");
- Intermediate ("I know at least 50% of the topic and I know where I can find more information about it. With help, I am confident I can talk with families or others about it"); and
- Novice ("I am not confident that I know enough about the topic to discuss with others").

The measure will be used to assist with workforce development and identify technical assistance needs in this area. By increasing staff knowledge and skills on the subject, it is anticipated that this will, in turn, lead to staff willingness to engage consumers and families in their work.

Objectives:

By July 2020, increase the engagement of families and consumers in the Family Health Services (FHSD) activities.

5-Year Strategies

- *Strategy 1: Develop and implement a structure to direct and coordinate Title V Family and Consumer Engagement Program*. DOH FHSD will establish a Family and Consumer Engagement Work Group to provide direction for engagement activities across all FHSD programs.
- *Strategy 2: Provide staff with professional development opportunities to increase their level of knowledge and skill.* Training and professional development will raise the staff level of knowledge and skill to provide family engagement activities.
- *Strategy 3: Develop and implement guidelines for family engagement programs to ensure best practices and quality family engagement activities*. The guidelines will be appropriate to the nature of the FHSD program, potential for family engagement, and available resources. Guidelines will encourage family engagement at every level of FHSD programs: 1) direct service programs; 2) population health programs that

do not provide direct services; and 3) programs that retain contractors to provide direct services.

- *Strategy 4: Increase the level of family engagement activities through partnerships with community based organizations that support and develop family engagement and parents as leaders*. Through partnerships with community based organizations there will be an increase in the level of family engagement activities in FHSD programs.

Strategy Development

The four strategies for SPM 2 were revised substantially based on an assessment of family/consumer knowledge and practices among the staff working on the Title V priority issues in FFY 2017. The revised strategies reflect a systematic method to help build greater capacity for family engagement among staff and programs. The strategies were developed in conjunction with the Title V Leadership Team (comprised of management and program staff leads for the Title V priorities), Hilopa'a F2FHIC, and the Hawaii Children's Action Network (HCAN). HCAN provided technical support, and assisted FHSD with the SPM assessment and planning.

Plans for Application Year Federal Fiscal Year 2018 (10/1/17-9/30/18)

FHSD will pursue these four strategies in FFY 2018 – 2021, designed to take advantage of the contributing factors, and surmount the challenges and barriers:

Strategy 1: Develop and implement a structure to direct and coordinate Title V Family and Consumer Engagement Program. DOH FHSD will establish a Family and Consumer Engagement Work Group (Work Group) to provide direction for family and consumer engagement activities across all FHSD programs. This strategy will take advantage of the commitment of staff, a contributing factor.

Establish Work Group (FFY 2017-2018): Recruit members and detail the roles and responsibilities of the Work Group. The Work Group will include at least one member from a community based organization that specializes in family engagement and training parents as leaders. Responsibilities will include:

- Researching best practices in family and consumer engagement;
- Identifying training, technical assistance needs, and securing this support;
- Coordinating family engagement activities across all programs; and
- Monitoring and evaluating family engagement activities.

Work Plan (FFY 2017-2021): The Work Group will develop a work plan that details the objectives, activities, responsible parties, and timeline. The work plan will be annually reviewed and revised. A template for the work plan is attached in Section V. Supporting Documents.

Evaluation Plan (FFY 2018-2021): The Work Group will develop an evaluation plan, and annually review and evaluate family engagement activities, the successes and challenges in implementing the workplan, and opportunities for improvement through the Plan-Do-Study-Act process.

Strategy 2: Provide staff with professional development opportunities to increase their level of knowledge and skill. Training and professional development will raise staff's level of knowledge and skill to provide family engagement activities.

Professional development (FFY 2018-2021): The Work Group will provide at least two professional development training opportunities for staff and community partners annually. One training will address the Ohana Nui program. Trainings will raise the level of knowledge and expertise among staff, and also to establish a common language and shared methodologies for family and consumer engagement among staff across all

programs.

Strategy 3: Develop and implement guidelines for family engagement programs to ensure best practices and quality family engagement activities. The guidelines will be appropriate to the nature of the FHSD program, potential for family engagement, and available resources. Guidelines will encourage family engagement at every level of FHSD programs: 1) direct service programs; 2) population health programs that do not provide direct services; and 3) programs that retain contractors to provide direct services.

Guidelines for public health programs (FFY 2017-2018): The Work Group will develop and adopt guidelines for FHSD public health programs working to improve population health.

Guidelines for direct service programs (FFY 2017-2018): The Work Group will develop and adopt guidelines for FHSD direct service programs.

Guidelines for community partners, contractors (Year 2018-2021): The Work Group will develop and adopt guidelines for contractors/community partners that provide direct services. The level of contractor involvement will be appropriate to the kind of direct services they provide.

Strategy 4: Increase the level of family engagement activities through partnerships with community based organizations that support and develop family engagement and parents as leaders. Through partnerships with community based organization there will be an increase in the level of family engagement activities in FHSD programs.

Gather family and consumer perspectives (FFY 2017-2021): Community partners will assist FHSD programs to solicit perspectives of families and consumers on a variety of topics that inform development and implementation of FHSD program policies and systems, and initiatives to provide outreach and education to families. Community partners will facilitate at least two projects each year for FHSD programs to gather opinions, perspectives, and priorities of families through focus groups, key informant interviews, and/or convenience surveys.

Calendar of family engagement opportunities (FFY 2017-2021): The Work Group will collaborate with a community partner that specializes in family engagement to develop and maintain a calendar of opportunities to conduct outreach and education to families, and opportunities for families to be engaged in FHSD programs.

Communication plan (FFY 2017-2021): The Work Group will collaborate with a community partner to develop a communication plan to promote family engagement. The plan may include development of brochures, fact sheets, and/or electronic communications, and pathways for dissemination of information.

Outreach and education (FFY 2017-2021): Community partners will assist FHSD programs to disseminate information and recruit parents for engagement opportunities, such as participation on advisory boards, attendance at meetings to offer input on specific issues or programs, or organizing activities with other families to participate in engagement activities.

FHSD commits to sponsoring a family representative to attend the annual AMCHP meeting in FFY 2018. This opportunity will be disseminated through community partners, and included in the calendar of family engagement opportunities.

Priority Need: Partner Engagement

Meaningful Partnerships was identified as a State Priority Measure (SPM) in the Title V 5-year needs assessment. To address the health needs of such a large population, partnerships are a cornerstone of maternal and child health. Title V agencies cannot do this work alone and are dependent on partners (contractors, stakeholders, consultants, etc.) to help assure the optimal health and development of MCH population. The Title V guidance requires states to report on Partnerships, Collaboration and Coordination as part of the Title V application and like many states Hawaii has no shortage of examples of ongoing partnerships.

Because FHSD is a multi-faceted division, there are many variations on how programs are administered and services procured. However, virtually all Title V programs work with partners and stakeholders routinely (some more than others and oftentimes, programs work with many of the same partners and populations). The challenge for Hawaii is to identify a systemic approach to work with partners in a comprehensive, consistent, and effective manner (using evidence based/best practices).

Although most Title V programs work in partnership, they may not always be aware that routine working relationships are also opportunities for improved partnership. Direct services programs may not always view the families they serve as program partners beyond the clinical services provided; or, how relationships developed through service contracts can help inform broader program planning and policy development. Other programs who do more systems work with coalitions, task forces, or committees may recognize partnerships as an important component of their work, but may not be clear on the Title V role as a partner, understand the value of the partnership, or have the skills to effectively advance the work of the partnership to improve MCH health.

Evaluation of the partnership work and using data-driven decision-making will help improve meaningful engagement with partners. Hawaii is using this State Performance Measure to help FHSD identify a process to strengthen staff capacity to develop meaningful partnership to improve maternal and child health.

The health of Hawaii's children and families depends on working with complex systems – medical, health care, early childhood, insurance, etc. Navigating through these systems depends on strong relationships, trust, and being respectful of the diversity of opinions. Director of Health, Dr. Virginia Pressler is moving forward with promoting "health as our shared value". This shared responsibility can only be achieved through meaningful and trusted partnerships with families, communities, and other systems.

Priority: Partner Engagement

The actual priority is to "Improve partner engagement in FHSD." FHSD will have the opportunity to examine best practices for meaningful partner engagement and to evaluate how these partnerships can lead to better health outcomes for children and families.

Objective: By July 2020, increase partner engagement in FHSD.

5-Year Strategies

Much of the work will focus on three areas: staff engagement, staff development, and collaboration. The timeline for implementing the strategies follows:

- Step 1 (2016-17): Internal FHSD workforce development focusing on partnership
- Step 2 (2017-18): Working with partners to study meaningful partnership continuum
- Step 3 (2018-19): Working with existing partners to move along the continuum
- Step 4 (2019-20): Bring new partners to FHSD programs.

The strategies will focus on three significant areas to help promote staff and partner buy-in and commitment.

- Staff Engagement. Many staff are still adjusting to the State Budget cuts in 2009, which eliminated positions and programs. FHSD suffered a major loss of staff and the MCHB lost an entire section focusing on Child Wellness. Many of the responsibilities of eliminated staff were shifted to existing staff's workload. The strategy of staff engagement around meaningful partnerships starts with the recognition that staff must be engaged to support this priority. If staff can see the value added in their —not a top-down priority assigned to them—then there will be more successful implementation and acceptance of the strategy and priority. Activities included in this strategy are as follows:
  - Determine definition of meaningful partnerships;
  - Develop self-assessment tool to measure partnerships;
  - Identify pilot programs or priorities to conduct Plan Do Study Act (PDSA) on meaningful partnerships.

- Staff Development. One of the key strategies for meaningful partnerships is to promote staff development. Once staff can see how they are professionally as well as personally growing from this priority, then there will be greater appreciation of this measure. Trainings and technical assistance are a quick way for staff to see a benefit to participation. Skills and tips learned around the process of this priority will help staff apply this to other aspects of their work. The specific activities include:
  - Determine indicators and benchmarks of Meaningful Partnerships;
  - Determine data collection needs and sources.

- Collaboration. Once staff feel comfortable in their knowledge, attitudes, and skills around meaningful partnership, then staff should be more willing to engage and collaborate with partners to identify best practices. Activities to support this include:
  - Convene partners to determine willingness to engage in the process of meaningful partnerships;
  - Conduct partner assessment of FHSD Partner Engagement;
  - Meet with partners to study and address successes, barriers, and challenges.

Hawaii will use its own spectrum of Meaningful Partnerships to determine the number and level of engaged partners working with Title V programs.

Networking	Coordination	Cooperation	Collaboration	Integration
				Interdependence
			Mutually beneficial	Mutually beneficial
		Sharing resources	Sharing resources	Sharing resources
	Aligning work and activities for common purpose	Aligning work and activities for common purpose	Aligning work and activities for common purpose	Aligning work and activities for common purpose
Exchanging information	Exchanging information	Exchanging information	Exchanging information	Exchanging information

Strategy Development

An environmental scan of best practices, research and studies, and policies and assessment of partner engagement was conducted. Strategies were developed based on recommendations from staff and best practices from other states including the MCHB State Technical Assistance Meeting. The preliminary 5-year plan objectives were developed by the Title V Leadership Team with technical assistance provided at the MCH Bureau State Technical Assistance Meeting held on April 5-6, 2016. Hawaii sent a delegation to the national Title V Technical Assistance Working Meeting. One of the running themes of the Small-Medium States Group was how to measure partner engagement.

State Performance Measure

Percentage of FHSD staff that have increased their knowledge on partner engagement.

The measure was developed as part of a survey that will be administered at Division-wide Title V staff meetings every 1-2 years.

Plans for Federal Fiscal Year 2018 (10/1/17 – 9/30/18)

FHSD will continue to work on the current activities discussed above. There will be continued technical assistance through the MCH-LEND Program to help with project management and partner engagement in October and December 2017. The Title V Leadership Workgroup will continue to work through its plan to pilot with the issue leaders and then slowly spread out to other FHSD programs. A progress update will be provided in next year's Title V report. Any needed changes to the preliminary 5-Year Plan will be made. Based upon guidance provided by AMCHP and the federal MCH Bureau, Hawaii will revise the strategies as needed.

Oral Health Report

Report on Federal Fiscal Year 2016 (10/1/15 – 9/30/16)

ESM 13.1

The FFY 2016 indicator for ESM 13.1 is “No” - The Title V program was not able to establish leadership for the State Oral Health Program (SOHP) under the direction of a dental professional and staff with public health skills. Although securing dedicated staffing is the top priority for the SOHP, there have been major challenges and barriers to achieving the six ESM project activities identified:

1. Recruit for Dental Director
2. Formal interview of candidates for Dental Director
3. Hire and orient Dental Director
4. Recruit for Program Specialist
5. Formal interview of candidates for Program Specialist
6. Hire and orient Program Specialist.

The Dental Director recruitment announcements were distributed nationally as well as locally with special attention on dentists with public health or experience working with underserved populations. The SOHP received 28 inquiries and 11 applications for the position. Of those, three failed to meet the Hawaii licensing requirement. A total of 6 candidates were interviewed. An offer was made; however, the candidate declined due to family reasons. A second candidate was unable to start till late in 2016 due to prior commitments and would consider reapplying later. A third candidate was still under consideration while references were being checked. The position remained under recruitment and applications were still being received.

Due to the difficulty of recruiting a qualified full-time Dental Director, the SOHP reduced Dental Director position to half-time and worked to establish/secure CDC approval to fund a new full-time position for Oral Health Program Manager to manage the CDC grant work. Although a Dental Director was not hired, the SOHP made substantial progress establishing a full-time higher level Program Specialist V position which will start recruitment in FFY 2017.

To increase leadership/staffing capacity, the SOHP entered into a partnership with the New York University-Lutheran Medical Center (NYU-LMC) Dental Public Health (DPH) Residency program which recently established a program in Hawaii. Since November 2015, the SOHP has been working with resident, Dr. Jennifer Domagalski, and faculty advisor, Dr. Steven Silverstein. Both dentists have been providing technical assistance (TA) and has been instrumental with finalizing publications, research and report writing, project planning, and policy development. In February 2016, the SOHP met with Dr. Jay Balzer, director for the residency program, and agreed to offer the SOHP as a possible placement for future residents. Without a dental school and given barriers to recruit a dental director, this partnership has helped to expand the SOHP leadership capacity substantially.

ESM 13.2

The FFY 2016 indicator for ESM 13.2 is No. The teledentistry pilot project at three early childhood settings to reach underserved, low-income, high-risk children and pregnant women was not completed; however much of the ground work to establish the pilot was completed. Most of the 16 ESM project activities were completed.

Project Activity	Project Status	
	FFY 2016 10/1/15-9/30/16	FFY 2017 10/1/16-9/30/17
1. Demonstrate need for project and barriers/facilitators that exist.	Completed	Completed Ongoing
2. Educate and inform community oral health stakeholders and others about the teledentistry delivery of care system and applications to Hawaii.	Completed Ongoing	Completed Ongoing
3. Develop planning committee for teledentistry projects.	Completed	Completed Ongoing
4. Develop proof of concept for teledentistry projects.	Completed	Completed Ongoing
5. Secure funding for three-year pilot project.	Completed, assured with adequate progress	
6. Develop program orientation for community partners, providers, and site staff to introduce concept.	Completed	Completed Ongoing
7. Identify locations and execute Memorandum of Understanding with three pilot sites.	Completed for 2 sites, 3rd site not participating	
8. Develop program protocols and policies and procedures for both dental services and case management.	Completed	Completed
9. Develop consents and other communications to parents.	Completed	Education materials under development
10. Purchase dental equipment and computer software.	Completed	Completed
11. Provide necessary training for providers and site staff.	Completed	Completed Ongoing
12. Develop evaluation plan including economic feasibility analysis.	Developing.	Developing
13. Teledentistry operational at three sites.	Operational 2 sites. Exploring options for additional site.	
14. Provide adequate case management to ensure participants establish a dental home.	Completed	Completed
15. Inform public of project results, lessons learned, and future considerations.	Completed Ongoing	Completed Ongoing

A grant from the Hawaii Dental Services Foundation was awarded in December 2015 for the pilot project. The DOH Developmental Disabilities Division's Health Hospital and Community Dental Services Branch is the lead for the project and is partnering with the Pacific Center for Special Care (PCSC) at the University of the Pacific, Arthur A. Dugoni School of Dentistry to provide technical assistance in developing the "Virtual Dental Home" (VDH) project.

FHSD participates on the planning team since the populations targeted for the pilot project are young, underserved children. Also the Women, Infant, and Children (WIC) services, one of FHSD's three branches, is participating in the VDH project. As noted, this measure also supports FHSD's state priority to promote telehealth in

Title V programs.

The first year of the pilot focused on program start-up, securing formal agreements; hiring and training of providers, case managers, and other site staff; purchase of dental equipment and teledentistry software and hardware; and establishment of program protocols and policies using PCSC's VDH program. The primary dental provider organization is the West Hawaii Community Health Center (WHCHC). It was decided not to include pregnant women as part of the VDH scope of work to simply the project and assure success for the pilot.

Several training sessions were conducted covering program design, engagement of community partners, roles and responsibilities of the dental team staff and community site team; as well as training on the use of the equipment. In addition, WHCHC dental providers were trained on how the VDH system relates to changes in the health care system, new science in prevention and caries management, use of the telehealth team concept, and legal issues including consent, HIPAA, and agreements. WHCHC's dental team will be collaboration with behavioral health specialists to create high quality supportive communications strategies for families to learn about and adopt health personal hygiene habits.

Clinical care began in July 2016, starting at WIC services. Evaluation plans are under development and evaluation will be ongoing. Once all pilot sites are completed, a report will be provided outlining the results of the program and economic feasibility analysis.

Given this new model of care, the VDH team has spent substantial effort on communications with stakeholders to help increase familiarity and comfort with the new technology. Ongoing meetings with stakeholders were conducted to provide timely information as the pilot has proceeded. A local advisory team of parents/caregivers, dental professionals, teachers and administrators has also been established to help guide the work and promote the project.

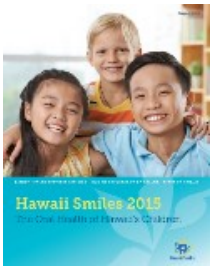
A second-year grant was submitted to HDS Foundation to continue the pilot project for a full year of operations to assure VDH can provide services effectively to children, collect data, conduct evaluation and assure quality improvement, implement new state legislation to allow for billing of telehealth services by Medicaid, and address any policy or administrative barriers to VDH service delivery.

ESM Development

Both ESM were drafted and reviewed by John Hopkins University staff providing Technical Assistance (TA) for ESM development and Maternal Child Health (MCH) Bureau staff. Based on feedback, the wording for the measures were changed and the indicator was revised from a "checklist" to a "Yes/No" measure. Objectives were set to capture progress on this measure on an annual basis. Title V staff working on oral health also participated in the AMCHP Technical Assistance session in April 2016. Staff found the sharing of information between states helpful in drafting ESM.

At the August 2016 in-state Title V grant review the NPM 13 oral health ESM received general approval. However, a suggestion was made to consider revising the ESM to checklists vs. using the "Yes/No" indicator to better capture progress. The ESMs were not revised this year due to limited staffing resources.

Other Oral Activities



One of the major successes for SOHP was the publication of Hawaii Smiles, a report on the 2015 3rd grade Basic Screening Survey (3rd grade BSS), conducted for the first time in Hawaii using a representative sample. The report confirmed that Hawaii's children have the highest prevalence of tooth decay in the nation and few Hawaii children take advantage of preventive measures to improve their oral health (like sealants). Also, as expected disparities by geography, income and ethnicity were also documented. The results were disseminated to agencies, key stakeholder organizations, policymakers, and through media release. The data helped to inform policy and planning decisions, including the State's Hawaiian Islands Oral Health Task Force implementation of a second-year CMS State Innovation Model (SIMS) grant. One of the SIM focus areas is oral health. Hawaii's leadership and partnership efforts to conduct the screening were also highlighted in an Association of State and Territorial Dental Directors (ASTDD) 'best practices' brief. http://www.astdd.org/state-activities-descriptive-summaries/?id=302

Being one of the last five states to complete a 3rd grade BSS, Hawaii was finally able to report BSS data to the CDC National Oral Health Surveillance System (NOHSS) for the first time in November 2015.

A funding proposal for the pilot school dental sealant project was submitted to the HDS Foundation and was awarded in 2015. The lead for this project is the DOH Planning Office. DOH partnered with an existing FQHC dental program in Hawaii County to identify a cost-effective and, therefore, sustainable service delivery and financing model for the provision of oral health services in a school setting. A report on the project economic feasibility as well as a start-up manual for Federally Qualified Health Centers planning to begin school dental sealant programs are forthcoming. Additional site pilot site is also under consideration.

The SOHP continues to build and maintain additional partnerships to leverage resources and funding to assure progress on oral health activities: Other collaborations include working with the DOH Chronic Disease Tobacco program regarding promotion of the Tobacco Quit Line among dental providers.

Report on Federal Fiscal Year 2017 (10/1/16 – present)

The following are some brief updates on the ESM and general oral health work.

ESM 13.1 Leadership/staff

- Part-time dental director hired 4/4/17, Gavin Uchida, DDS, MBA. Dr. Uchida is a pediatric dentist and recently established his private practice in Honolulu. He also serves children at Shriner's hospital part-time.
- Part-time Office Assistant position was filled 2/1/17.
- Recruitment for the full-time civil service Oral Health program manager position began in October 2016. Two interviews were conducted/ however neither applicant March 2017, but both were either not selected or declined employment offer. The position is currently under recruitment.

ESM 13.2 Virtual Dental Home

- Funding received for Year 2 of pilot project from HDS Foundation. Year 3 funding application due August 1, 2017.
- Screening occurring at WIC and Head Start sites 250 children provided services. The third site preschool site lost funding and is closing. Considering expanding to local elementary schools and community organizations who have expressed interest.
- Hawaii State Medicaid Memo dated May 2, 2017, Medicaid now reimburses telehealth procedures, including teledentistry related dental procedures. Retro-active to January 1, 2017. WHCHC is now in the process of securing reimbursement for VDH services provided.

- A grant has been submitted to the HMSA Foundation for a second pilot site on Maui. Provider Partner is Native Hawaiian Health Center, Hui No Ke Ola Pono. VDH Sites will be Early Head Start. Head Start, WIC, and Hale Makua Health Services, residential elderly.

Other Oral Activities

- FHSD partnered with HDS Foundation to conduct a press conference on the findings from the third grade oral health screening. Hawaii's successful communication efforts were highlighted at a CDC oral health grantees meeting in December 2016 due to the extensive media coverage and front page story in the major daily newspaper. Hawaii's partnership efforts used to conduct the screening were also highlighted at the grantees meeting. In May 2016 Hawaii was asked to present on a national ASTDD webinar on 'Turning Data Into Action: The Importance of Data Dissemination.'
- The data for the DOH data publications has helped raise awareness of oral health issues for Hawaii's population particularly among funding organizations. Three Hawaii Federally Qualified Health Centers used the data in successful federal HRSA grant applications to expand oral health services. The data was also used to secure Denta-QUEST Foundation funding for the Hawaii Public Health Association to address oral health disparities and promote community networking.
- Concerned about the 3rd grade screening findings, FHSD is conducting an oral health screening of Head Start/Early Head Start children. A Steering Committee of private-public partners has been convened and the Hawaii Children's Action Network (HCAN) has been contracted to manage the project. HCAN submitted an HMSA Foundation grant to support screening and convene stakeholders to develop a state children's oral health plan. HMSA is the local Blue Cross, Blue Shield affiliate.
- Staff working on oral health attended training on Project Management provided by MCH LEND faculty to develop work plans to assure progress on the ESMs. Work plans can be found in Supporting documents.

Factors Contributing to Success

The CDC oral health grant has helped support program activities to rebuild the data surveillance system, promote partnerships and coalition building. The CDC "cooperative agreement" approach to working with states promotes close TA and consultant to assure continued progress on the five strategy areas. FHSD continues to also benefit from ongoing ASTDD TA on virtually all strategy areas for the cooperative agreement. ASTDD TA has been invaluable for content expertise and guidance since the SOHP has not had a dedicated dental professional or oral health epidemiologist on staff.

Other assets that have helped drive progress include:

- many dedicated oral health stakeholders and community-based programs, and
- strong legislative and administrative support for oral health as a priority.

Lastly, locating the oral health program in the MCH Title V agency, with a culture of collaboration and partnership, helped facilitate:

- teamwork among Title V staff to effectively manage the grant activities without dedicated staffing, and
- develop partnerships with key internal and external stakeholders to leverage resources.

Challenges, Barriers

The primary barrier to progress for the SOHP continues to be lack of dedicated public health leadership and staffing to work on building the SOHP capacity. Although securing dedicated staffing is the top priority for the SOHP, there have been major barriers to achieving greater progress in this area. Also, establishing new staffing positions is

often time consuming and requires a lengthy approval process.

The SOHP did not anticipate the difficulty in recruiting a qualified applicant for the Dental Director position. Most of the candidates that have met the Hawaii licensing requirement have largely clinical skills, but little public health or program management background. A clear need has been demonstrated for a full-time program manager with strong public health skills. Thus, the SOHP reconfigured the staffing plan accordingly. Recruitment for a qualified public health professional will be challenging given the limited term of the grant funding.

National Performance Measures

NPM-13A: Percent of women who had a dental visit during pregnancy

The 2020 state objective is to increase the proportion of pregnant women who have a preventive dental visit during pregnancy to 45.0%. In 2013, the estimate for Hawaii (46.8%) met the objective, but was below the national estimate of 51.3%. The state objective for 2021 was carried over from 2020. The percent of women who had a dental visit during pregnancy has increased since 2010 (33.8%). Groups at higher risk included women between the age of 20 and 24 (32.1%), and unmarried women (33.7). The current estimate for Hawaii (46.8%) has increased since 2011 (37.0%). Data from 2014 PRAMS survey not available at time of reporting.

NPM-13B: Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

The 2020 state objective is to increase the proportion of children, ages 1 through 17, who had a preventive dental visit in the past year to 87.0%. Data from 2011-2012 show that the estimate for Hawaii (83.1%) has not met the state objective and was above the national estimate of 77.2%. The state objective for 2021 was carried over from 2020 as no data has been available to assess progress for several years. Risk groups included children ages 1-5 (69.6%), children ages 12-17 (85.1%), children whose mothers are not married (74.8%), children from households below 100% FPL (69.4%), and children from households 100%-199% FPL (80.1%). The current proportion of children, ages 1 through 17, who had a preventive dental visit in the past year (83.1%) has decreased from 2007 (86.9%). Data from 2016 survey not available at time of reporting.

National Outcome Measures

NOM-14: Percent of children 1-17 with decayed teeth in past 12 months

The related Healthy People 2020 Objectives are to reduce the proportion of children ages 3-5 who have dental caries experience in their primary or permanent teeth to 30.0%) and to reduce the proportion of children ages 6-9 who have dental caries experience in their primary or permanent teeth to 49.0%. In data from 2011-12, the proportion of children with tooth decay in the past 12 months was 19.6% which was similar to the national estimate (18.8%). Higher risk groups include children 6-11 years of age (25.8%), children with at least one parent that was born outside the US (29.3%), where English was not the primary language spoken in the household (34.2%), and those that live below 100% Federal Poverty Level (28.8%) or in households with Federal poverty levels from 100-199% (26.7%). Data from 2016 survey not available at time of reporting.

NOM-19: Percent of Children in Excellent or Very Good Health

There are no related Healthy People 2020 Objectives. In data from 2011-12, the percent of children in excellent or very good health was 86.0% in Hawaii which was similar to the national estimate (84.2%). There has been no change over time with 86.7% in 2003. Higher risk groups could not be reported due to small numbers. Data from 2016 survey not available at time of reporting.

State Performance Measure 1: Telehealth Report

Report on Federal Fiscal Year 2016 (10/1/15 – 9/30/16)

The FFY 2016 indicator for the SPM 1 is 8 out of a total of 72. A copy of the completed data collection form can be found in the supporting documents.

The use of telehealth continued to increase including programs within the Department of Health (DOH), statewide hospitals, the University of Hawaii, state legislators, and our Congressional representation. These efforts have been supported by the HRSA funded Pacific Basin Telehealth Resource —based in the University of Hawaii—that works to help stakeholders collaborate on telehealth activities.

Hawaii's Congressional Senator Brian Schatz and his aides met several times with Department of Health, University of Hawaii, and hospital representatives to discuss ways to increase the use of telehealth in Hawaii. Senator Schatz also convened a statewide meeting in January 2016 to discuss current issues in telehealth and he introduced federal legislation to support more telehealth activities under the Medicare rules.

In 2016 the Governor signed Act 226 requiring the state Medicaid program to reimburse for telehealth services and ensures telehealth is covered when originating in a patient's home and other non-medical environments. The Administration and legislative leaders hope to make Hawaii one of the nation's leaders in telehealth.

Based on the priority placed on telehealth by the Governor and the Director of Health, the Title V working group decided to include increasing the use of telehealth as a State Performance Measure. This fit well into the telegenetics training and service activities that were being carried out by the Department of Health Genomics Section under the FHSD as part of the HRSA funded Regional Genetics Collaboratives. Therefore, it was natural to have the Supervisor of the Genomics Section and Project Director for the Regional Genetics Collaborative lead the Title V telehealth activities.

To develop the measures for the telehealth activities, the Title V telehealth work group reviewed the performance measures and scoring used by the HRSA MCHB funded programs. We chose the ones that best fit the topics covered by our proposed telehealth activities and revised the wording to fit telehealth as necessary. We reviewed the performance measures for FFY 2016 and completed the information for the baseline reporting.

Report on Federal Fiscal Year 2017 (10/1/16 – present)

Within the Department of Health, the Director continues to support telehealth as one of the top priorities for the Department. A presentation about the Title V telehealth activities was part of the Department highlights presented at the in-person meeting with the Governor in December 2016. Our activities align well with the Governor's plan to support telehealth activities in the state. Third party payers and providers in the state are still working on developing the policies to implement Act 226 (2016) that removed the originating site restrictions so telehealth can be done to a person's home or work as of January 1, 2017.

We also continue to work with Hawaii's Congressional Senator Brian Schatz and his aides to continue enacting policies that support the use of telehealth. Senator Schatz continues to advocate for changes to federal Medicare policies and local state policies for telehealth. We are working with the University of Hawaii as part of the planning group for the next statewide meeting in October 2017 of telehealth supporters and providers which is a follow-up to the meeting held in January 2016.

Within the Family Health Services Division (FHSD), telehealth use is increasing for meetings, training, and

education for staff and external partners. FHSD support continues for efforts to implement or increase telehealth clinical and service provision for genetics, newborn screening, early intervention, and home visiting activities. Other FHSD telehealth activities include the Office of Primary Care and Rural Health's support of 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 a pilot teledentistry program at three early childhood locations in Kona on Hawaii Island. The Early Intervention Section developed a telehealth work group to plan, implement, and evaluate using telehealth to provide early intervention services to families and training to staff and providers.

In May and June 2017, videoconferencing equipment was installed at the District Health Offices in Maui, Hilo, Kona, and Kauai. Training on the use of the equipment for the statewide FHSD staff is on-going. This will facilitate further use of telehealth by the neighbor island staff and access for families to receive telehealth services. The FHSD staff has shown enthusiastic support for learning more about telehealth and how it may fit into their work with families, providers, and staff.

The Genetics Program worked with the University of Hawaii Distance Course Design and Consulting Program to develop, design, test, and implement a ten-module online telegenetics training course for genetics providers and program administrators. The online training course is part of a curriculum that also includes two webinars and a one day in-person session. An additional contract was executed in July 2017 to revise the on-line telegenetics modules with public health/Title V content to train the Title V staff and providers. The HRSA funded Pacific Basin Telehealth Resource Center is working with the Genomics Supervisor to develop the in-person training to accompany the online telehealth training. Training is expected to begin in October 2017.

Factors Contributing to Success

The major factor contributing to success towards expanding telehealth in Title V programs is support from the Governor, Department of Health 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 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 Genetic Services Collaborative 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 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. There is not one staff person that is fully dedicated to doing telehealth activities so developing and implementing activities is a slower process. The Genetics program, as telehealth lead, works collaboratively with internal and external partners as much as possible to expand telehealth activities with the limited staff resources.

State Performance Measure 2: Family/Consumer Engagement Report

Report on Federal Fiscal Year 2016 (10/1/15 – 9/30/16)

The baseline data for SPM 2 is 23.9% of FHSD staff increased their knowledge on family/consumer engagement. The data was collected in preparation for an annual Title V 2015 meeting. Participants represented the Title V agency's 28 programs and neighbor island units. The data is a baseline that was used to set up SPM objectives.

Most of the FFY 2016 activities focused on finalizing the selection of the SPM, development of preliminary strategies, and collecting baseline data to set objectives. The draft SPM was reviewed by John Hopkins University staff providing TA for ESM development (although this was a state measure, not an ESM) and MCH Bureau staff. Objectives were set to capture progress on this measure on an annual basis.

The family engagement state priority was shared as part of the Hawaii 5-year plan at the 2016 AMCHP Technical Assistance session in April. Staff found the sharing of information between states helpful and realized this SPM was rather unique.

At the August 2016 in-state Title V grant review the family/consumer engagement SPM received general approval.

A team of Title V staff, management, and a representative from Hilopa'a F2FHIC worked together on the family engagement measure, but a designated staff leader has not been found to work on this to date; thus, FHSD considered contracting for additional assistance to assure progress on this work.

FHSD works closely with the Hilopa'a F2FHIC to address family and consumer engagement. In developing the Needs Assessment, priorities were discussed with groups including the Community Children's Councils and Developmental Disabilities Council that included family members.

In 2015, the FHSD Office of Primary Care and Rural Health (OPCRH) supported the Parent Leadership Training Institute (PLTI) and graduated its first class of parent leaders. PLTI is an evidence-based leadership training program developed by the Connecticut Commission on Children. The program has been effectively used in other communities across the nation to cultivate a culture of civic engagement among parents, working to advancing positive changes to the policies and systems that support children.

In January 2016, Title V staff attended a training on Focus Groups which contained information on working with families and listening to their critical perspective. Challenges identified included administrative barriers to support parent stipends for transportation, child care, and time/effort for participation, as well as practical aspects of constructively using information shared by families.

Parent and consumer engagement helped support Title V and other health priorities in various ways, including the following examples:

- Family and Consumer Partnerships: Family members are part of many Task Forces and Advisory Councils including the Child Abuse Prevention Planning Council, Fetal Alcohol Spectrum Disorders Task Force, Hawaii Early Intervention Coordinating Council, Newborn Hearing Screening Advisory Committee, Newborn Metabolic Screening Advisory Committee, State Systemic Improvement Plan for Part C, Western States Genetic Services Collaborative.
- Advocacy: Families supported and helped pass the law requiring 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 and many were present at the bill signing by the Governor.
- Strategic and Program Planning: A family leader from the Hilopa'a Family to Family Health Information

Center 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 Title V priorities.

Report on Federal Fiscal Year 2017 (10/1/16 – present)

The Title V programs conducted several key activities in FFY 2017 that lay the foundation to build a comprehensive Family and Consumer Engagement Program in FHSD.

Retained a community organization that specializes in family engagement. FHSD retained the Hawaii Children's Action Network (HCAN), a community based organization that specializes in family engagement programs. HCAN provided technical support, and assisted FHSD with the following tasks: 1) completed an inventory of programs where family and consumer engagement activities are being used; 2) assisted Title V leadership to review the informational materials from AMCHP and the MCH Bureau; 3) provided assistance in developing realistic and achievable strategies and outcomes to advance family and consumer engagement; and 4) maintain the Parent Leadership Training Institute, an evidence based program designed to cultivate parents as leaders and advocates for their children.

Inventory of family and consumer engagement activities – Each of the programs completed a survey of their family and consumer engagement activities, with wide ranging results. In some cases, activities were progressing with positive results; in other cases, programs are incorporating family engagement activities, but are unaware that those activities qualify as "family engagement." Overall, the inventory revealed a need for training and technical support to establish a common understanding of family engagement, shared methodologies, and coordination of activities across programs.

Developed strategies for family and consumer engagement – The potential for family engagement activities among Title V programs largely depends on their structure and purpose. HCAN assisted FHSD to identify three categories of programs that have distinctly different challenges and opportunities for family and consumer engagement:

Direct service programs (Children with Special Health Needs Branch, WIC) - Direct service programs provide the greatest opportunities to engage families and consumers at higher levels of involvement in policy and advocacy. FHSD staff have direct contact with parents, and this provides them the opportunity to develop relationships of trust necessary to recruit parents open to getting involved. Direct service programs also have a defined population to solicit perspectives and feedback on program improvements through satisfaction surveys.

Population health programs that work on the systems level (Telehealth, Oral Health Program, Safe Sleep, Reproductive Life Planning, Breastfeeding, Child Abuse and Neglect Prevention, Adolescent Health) - Programs that address systems change to improve population health have little, if any, direct contact with families and consumers. For these programs, family engagement activities have the potential to inform the development, monitoring, and quality improvement of systems and policies. Gathering information on the priorities and perspectives of families and consumers is especially important in the State of Hawaii where there are diverse perspectives among the different ethnic and cultural groups, and communities are spread across seven inhabited islands with distinctly different needs and resources. Family and consumer engagement methods to solicit perspectives and feedback include focus groups, key informant interviews, convenience surveys, polls, and consumer satisfaction surveys. These methodologies have the potential to provide FHSD staff with valuable information about the quality and impact of the services they provide.

Programs that contract with community based organizations to provide direct services (Developmental Screenings, WIC) - Programs that contract with direct service organizations could promote, or in some cases, require family engagement activities. For example, contractors are frequently required to administer a consumer satisfaction survey. Not only is this a method for FHSD to monitor the quality of the services provided by contractors, but also an opportunity to solicit feedback and perspectives of the families and consumers they serve.

Parent Leadership Training Institute (PLTI) – FHSD engaged HCAN to provide the PLTI evidence-based leadership curriculum and is currently working to recruit a second cohort of PLTI participants. HCAN will also develop a network of PLTI graduates. This network of parents, willing to attend the 20-week civic engagement training, will provide a valuable resource as FHSD develops its Family and Consumer Engagement Program. They will potentially be able to assist with recruiting families and consumers to be involved in advisory board opportunities, act as a parent representative at events, and organizing families and consumers in their community to advance issues or provide perspectives on FHSD initiatives.

Ohana Nui – The Directors of the Department of Health and Department of Human Services worked with the ASPEN Institute to study a Two-Generation model, and adopted the *Ohana Nui* ("Extended Family") approach for the generational aspects of engaging with families. FHSD recognizes the culturally appropriate need to address multi-generation families in Hawaii and include them as family and consumer partners.

Contributing Factors to Success

Several positive contributing factors were developed and/or strengthened in the past year, and will improve the ability of FHSD to build its Family and Consumer Engagement Program:

- *Commitment*: Staff recognize the importance of family engagement, and are committed to improve on this effort.
- *Direct services*: FHSD has many programs and services that work directly with families and consumers. These programs have great potential to recruit and engage families and consumers.
- *Multi-generation program*: At the departmental policy level, the Directors of Hawaii's Department of Health and Department of Human Services are working with the ASPEN Institute to study the Two-Generation model, and adopt 'Ohana Nui ("Extended Family") to engage members of multi-generational families.
- *Family leadership curriculum*: In 2015, the FHSD Office of Primary Care and Rural Health (OPCRH) supported the PLTI, and graduated its first class of parent leaders. Development of a second PLTI cohort is currently in progress. HCAN is working to build a network of PLTI graduates, with the potential to work with FHSD to increase family and consumer engagement at all levels.
- *Parent representative*: FHSD is committed to supporting a family member to attend the AMCHP meeting.

Challenges and Barriers

Several issues remain challenges to expanding family engagement programs in FHSD:

- *Parent stipends*: Procurement requirements make it difficult to provide parent stipends for transportation, child care, and time/effort, as well as practical aspects of constructively using information shared by families.
- *Integration of PLTI into Title V programs*: FHSD lacks the infrastructure is needed to support integration of PLTI graduates and parent leaders into Title V programs as partners.
- *Ohana Nui*: The 'Ohana Nui approach has not been disseminated to program level staff.
- *Staff knowledge and expertise*: Departments and staff are at varying levels of knowledge and experience with family engagement programs, and there is no common vocabulary or shared methodologies for family engagement.

- *Administration*: Although staff in each program are aware of the need to increase family and consumer engagement, there is no group tasked with directing and coordinating the different activities across FHSD programs, and externally with community partners. Rich opportunities exist in collaborating to gather parent perspectives, sharing in opportunities for families and consumers to get involved, and leveraging resources for outreach and education.

State Performance Measurement 3: Partner Engagement Report

Report on Federal Fiscal Year 2016 (10/1/15-9/30/16)

In FFY 2016, 13% percent of FHSD staff increased their knowledge on partner engagement to an "expert" level. This is the baseline data collected for this measure. The data was collected through a survey conducted in December 2015 as part of a FHSD meeting focused on Title V. Participants represented key staff from all 28 FHSD programs and neighbor island offices. Staff were asked about their knowledge/competency around Partner Engagement.

There is a large percentage of staff who have intermediate and novice level knowledge on Partner Engagement (87%) since many programs do work in partnership; although few staff report "expert" level ability. Only 6 felt they were expert (I know the topic quite well and am confident talking to families or others about it); 27 felt they were Intermediate (I know at least 50% of the topic and know where I can find more information about it – with help, I am confident I can talk with families or others about it); and 13 felt they were Novice (I am not confident that I have enough knowledge about the topic to discuss with others). The survey reveals this is an area where staff can benefit from additional support. The same cohort of staff participants will be asked this question in future surveys to see if there is an increase in knowledge in any of these areas.

FHSD staff reaffirmed the importance of partner engagement and endorsed the State Performance Measure. FFY 2017 will be used to find resources, technical assistance to plan and implement the capacity building efforts.

Part of the challenge to build FHSD workforce capacity has been the number of vacancies within the FHSD leadership including the Division Chief when Ms. Danette Wong Tomiyasu left in January 2015 to fill a DOH Deputy Director position.

Report on Federal Fiscal Year 2017 (10/1/16-present)

The focus for FY 2017 was on piloting the work with the Title V Leadership Workgroup through previewing the training, assessment tools, and strategy development. As part of a partnership with the Maternal and Child Health Leadership Education in Neurodevelopmental and Related Disabilities (MCH-LEND) program, the workgroup members were invited to participate in MCH-LEND trainings.

The trainings were: Program Management, Working Across Generations – Baby Boomers, Millennials, etc., Mediation for Managers, Facilitation Training, Design for Behavior Change, Graphic Design Basic, and Introduction to PowerPoint. Based on reviews and comments from participants, the trainings will be revised to meet the needs of FHSD staff.

A tool to identify and measure partners was developed by MCH LEND faculty and reviewed by the Leadership Team. After the tool is finalized, it will be piloted with the Title V Issue leaders and a follow-up Partner Satisfaction Survey will be developed. The Leadership Team will plan to the disseminate the survey, analyze the data, and determine follow up based on results including identifying training and TA.

The MCH-LEND program also provided training and TA to help Title V Issue leaders develop detailed work plans

to assure progress on the Evidence Based/Informed Strategy Measures (ESM) selected for each National Performance measure (NPM). The work plans required FHSD staff to identify partners or potential partners to assist with the work plan activities. This information will be used to "assess" the scope of partners involved in the Title V priorities and will be used to launch discussions to assure staff are working with the appropriate partners to help advance their work plans. Work plans will be shared with partners to get their buy-in, including families and consumers where appropriate. From this activity, the Leadership Team can develop a detailed work plan.

Factors Contributing to Success

Many of the Title V Programs do work in partnership. In past strategic planning efforts, partnership was identified as one of the strengths of the Division. With over 150 purchase of service contracts, the Division works closely with many community based organizations to assure services are provided to underserved and high risk populations throughout the state. It is likely there may be best practices within the Division that can be documented and shared with the program staff.

One of the key factors of the success of this endeavor is leadership support from the current Administration's highest level to the Division management team who all strongly support collaboration and partnerships. The current Administration has placed a high value of inter-agency collaboration, selecting state Department directors and deputies who strongly practice this value. This Administration supports collaborative efforts to leverage and maximize use of limited state resources.

MCH LEND faculty provided local TA and support for the development of surveys and tools to assessment staff capacity and training needs.

As a field in public health, MCH has as always promoted the importance of partnerships and collaboration as a core value. The state Title V agency also reflects this value in much of its practice. Although, the Division could benefit from a dedicated effort to educate staff on the key concepts and best practices to develop effective partnerships.

Challenges, Barriers

Because Hawaii is a mix of urban and rural communities and has a multitude of different races and ethnicities, Hawaii needs to work with partners of all different types and backgrounds. In addition, because Hawaii is an island-state and remote from the continental states, staff must depend on each other and partners for services and support. Relationships are essential and yet not all are treated the same for various reasons – geography, service providers in the area, capacity, and staff engagement.

Taking a critical look at FHSD programs and services and how they engage with partners will not be easy as Hawaii may find areas of disparities with the number and types of partners that are in the communities. Not all programs may see themselves as working with partners and may not see the value in exerting efforts to improve relationships that they may not think exist. It is critical to have a clear definition of partnerships and partners since "partners" come in various forms.

Other challenges may come from staff as well as partners. Some of the challenges from staff may include:

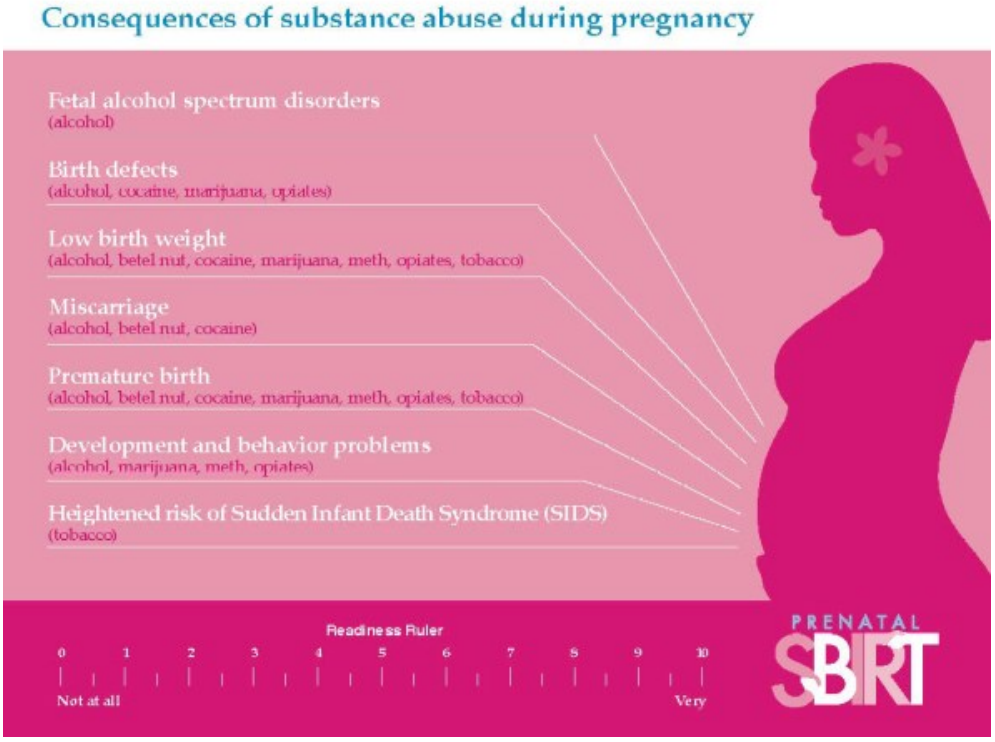
- Assuring training and TA are engaging and relevant
- Resistance of managers/programs to try new approaches/techniques;
- Unwillingness to engage due to workloads or time constraints;
- Discomfort at hearing what others may perceive as weakness;
- Inability to recognize constructive criticism as an opportunity for improvement.

Other Programmatic Activities

The Department of Health (DOH) has several projects to reduce substance use, including opioids.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a 2-year privately funded project of the DOH, the Hawaii Maternal Infant Health Collaborative, and Hilopa`a Family to Family Information Center. The purpose is to train all Medicaid prenatal care providers (except the Federally Qualified Health Centers) on SBIRT–an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

Materials developed include: a provider training manual; a Substance Use Treatment Provider directory by community; and a common referral form that complies with HIPAA and 42CFR, and referral guidelines. Insurance reimbursement process for Brief Intervention was negotiated. Training with Ob-Gyn providers is underway.



Hilopa`a also developed training curriculum on SBIRT, targeting adolescents. Training of pediatricians, in collaboration with AAP-Hawaii Chapter, is also underway.

The DOH Alcohol and Drug Abuse Division obtained a federal 5-year grant from SAMSHA to train primary care providers on SBIRT. The work will establish a single-point of referral for providers statewide. The long-term goal is to have SBIRT recognized as community standard of care and integrated into primary care practice.

The EMS/IPCS has a two-year grant from CDC to develop a state plan for opioid prevention. The Director of Health convened an Executive Committee that includes agency heads, major insurance purchasers, law enforcement, and medical providers. The Committee will work with partners to develop recommendations by September 2017 and finalize a state plan by March 2018. The plan will incorporate best practice guidelines for opioid control.

The DOH is developing a claims data base that will contain Medicaid, Medicare, and government employees insurance claims data. This data system will allow monitoring of medical claims for over 50% of all births in Hawaii.

II.F.2 MCH Workforce Development and Capacity

With over 300 employees and an annual budget of $97.5 million, the Family Health Services Division is one of the largest divisions in the DOH. FHSD continues to focus on the four core operational issues identified through a strategic operations planning 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; are being used to support efforts in the four operational areas. The Title V leadership team used the new grant guidance to explore different ways of working on the needs assessment and block grant report. Dr. Lu's emphasis on people, processes, and products were overlaid on the core operational issues:

People = Partnership Development and Workforce Development
Processes = Operational Effectiveness
Products = Quality Integrative Programs

In recognition of Dr. Lu's 3 P's mandate, FHSD identified new ways to transform FHSD's workforce to build capacity and improve effectiveness. One of the first initiatives was to examine how FHSD conducts the Title V grant process. Normally, the grant is directed from the Division level to the branches and program. In 2015, FHSD formalized a Title V Leadership Committee to guide and support the entire Title V planning, evaluation, assessment and reporting process. The Committee is comprised of highly skilled program staff leading efforts on the Title V NPM/SPM, FHSD management, neighbor island nurses, Division epidemiology/data staff, and Ms. Leolinda Parlin of the Hilopaa Family to Family Information Center (HF2FIC). Ms. Parlin's participation ensures family perspectives are considered in decisions regarding Title V planning. With the new grant guidance, the Committee operates as a learning collaborative to understand the opportunities provided by the Title V transformation and direct how Hawaii can best utilize Title V as a resource. The Committee is critical to transforming the way Title V work is completed in Hawaii.

The preparation for the 2016 Title V Review exemplified the concepts of FHSD transformation, using data to inform decision-making, and sharing findings from the needs assessment. The Title V Planning Committee developed the Hawaii presentation together, identified staff and key stakeholders to invite. Information and public input materials were shared with all invitees and staff who do not work directly on the annual report. A short video was developed for FHSD staff to view in preparation for the grant review – providing brief information on the Title V block grant and a short update on each of the national and state priorities.

Hawaii always views the annual Title V Review as an opportunity to provide an overview of the Division's programs and resources, priorities, updates, including DOH and the Governor's Administrative developments. While the presentation is geared for grant reviewers, the Title V Planning Committee helped plan the event to effectively use this opportunity to also inform and *engage* key stakeholders and FHSD staff in Title V. Normally about 50-60 invitees attend the Review each year. Feedback from participants is always very positive. The FHSD PowerPoint presentation prepared for the grant Review is now used as an orientation for new (and existing) FHSD employees. It is often used by staff for presentations to the community and stakeholders.

The Title V grant review resulted in no required changes to ESM, but did provide important feedback for improvement. A number of changes have been made to the report and 5-Year Plan as a result. To assure adequate

progress on all the Hawaii ESM measures, the FHSD Title V Committee decided to pursue development of detailed work plans for each NPM. Plans were developed in partnership with MCH LEND faculty to provide staff training on project management to build planning skills and develop a standard template for ESM work plan to include tasks, activities, timelines, resources (including identification of key partners). The plans can be found in the Section V Supporting Documents.

In December 2016, FHSD convene key program staff to present draft work plans on the Title V national and state measures to collect input and identify possible collaborations across Division programs.

Title V staff took advantage of various MCH and AMCHP opportunities 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 sent a team to the HRSA Title V Technical Assistance Working Meeting in April and received TA and learned from other states. Hawaii used TA from Johns Hopkins University Strengthening the Evidence efforts, MCH Bureau Learning labs, and national experts. 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.

FHSD partnered with Hawaii MCH LEND to provide ongoing training for the Title V Leadership Committee as well as Division staff. Training topics provided include:

- Project Management
- Working Across Generations
- Mediation for Managers
- Meeting Facilitation Training
- Design for Behavior Change
- Effective Presentations: Introduction to PowerPoint and Graphic Design Basics.

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 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 such as Community Paramedicine training that utilizes paramedics to provide primary care in rural areas.

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 Protective Factors to prevent CAN.

- Primary Care office conducts presentations routinely on loan repayment opportunities to public and private health care/medicine school programs as well as Hawaii Medical Education Council.
- WIC staff conduct breastfeeding training seminars to community providers.

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

II.F.3. Family Consumer Partnership

Family/consumer partnerships with FHSD include:

- Title V Block Grant development and review: Ms. Leolinda Parlin, Family Voices/Hawaii Leader and Director of the Hilopaa Family to Family Health Information Center (F2FHIC) is a member of the FHSD leadership team responsible for the Title V needs assessment; identifying and selecting priority issues, performance measures, and strategies; and developing the Title V grant application. Ms. Parlin's participation ensures family perspectives are considered in decisions regarding Title V planning.

- Title V planning for adolescent health: Due to limited staffing/resources for adolescent health, the Adolescent Coordinator partnered with the Hawaii Maternal Child Health Leadership Education in Neurodevelopmental & Related Disabilities (MCH LEND) program faculty to conduct trainings to pediatric providers on adolescent screening.

- Title V planning for children with special health care needs: Ms. Parlin is assisting the CSHNB/Children and Youth with Special Health Needs Section (CYSHNS) with the work on ESM #12.1 - The degree to which the Title V Children and Youth with Special Health Needs Section (CYSHNS) promotes and/or facilitates transition to adult health care for YSHCN. A meeting with a teenaged youth with special health care needs and her family was conducted as an in-service for staff to better understand the perspective of teenagers in the program. This teen will be traveling with the FHSD staff to the next AMCHP conference and her perspective will help inform planning and services for children.

- Advisory committees: Family leaders/partners of diverse ethnicities participate on various councils, committees, and collaboratives related to FHSD programs including:

  - Child Abuse Prevention Planning Council
  - Early Childhood Comprehensive Systems Impact Strategic Management Team
  - Hawaii Early Intervention Coordinating Council
  - Newborn Hearing Screening Advisory Committee
  - Newborn Metabolic Screening Advisory Committee
  - State Systemic Improvement Plan for Part C
  - Western States Genetic Services Collaborative

- Quality improvement: In 2016, Hawaii received the Early Childhood Comprehensive Systems Impact (ECCS Impact) grant focusing on developmental screening and quality improvement. Family engagement is a key component of the grant and representatives from Hilopa'a Family to Family Health Information Center and The Family Hui Hawaii (TFHH) (an organization that runs parent-led family support groups) are on the ECCS Impact advisory team. TFHH conducts developmental screenings with families and gives family-centered feedback to the ECCS Impact advisory team. TFFH also assists with testing quality improvement measures. For example, in the beginning of the project, TFFH reported that not many parents completed the screening tool (ASQ and ASQ-SE). After raising this as an issue facing many families, TFFH staff focused efforts on individual families to complete the ASQ. TFFH reported that providing small incentives at family fairs helps with increasing families completing the ASQ. Ms. Cherilyn Shiinoki, Executive Director of TFFH, shared a critical piece of information where she observed, "In general, I think that parents don't do the screens on their own initiative unless they think something is wrong. They are okay with doing them as part of a program and then see the value of it but on their own, not so much. … Those who think something is wrong and still don't

take the screen are probably afraid to get confirmation of their concerns or are worried about stigma, etc." This feedback from the family organization provided important information to the screening efforts as one of the goals is to increase the number of families completing the ASQ and the work group will implement steps to assist families and address their concerns.

- Messaging: Safe Sleep Hawaii and MCH Branch continue to work with family champions and the state Department of Human Services (DHS) to collaboratively develop a public awareness campaign on safe sleep practices for families and providers. DHS revised administrative rules for license child care providers regarding health and safety to include sleep practices.

In 2016, FHSD added a state priority on family and consumer engagement in Title V programs and a State Performance Measure on increasing the engagement of families and consumers in FHSD activities. This was done to support parent partners to more effectively use opportunities in a changing health care environment. The state priority recognizes that there needs to be Division-wide attention and a systemic effort to focus on family and consumer engagement starting with Title V Priorities and spreading through all FHSD programs. Much of the Title V staff's work in the next year will be to engage with, family and consumer partners to develop a plan that meets the needs of all, and to support Title V staff's capacity to focus on family and consumer engagement.

FHSD retained a Hawaii Children's Action Network (HCAN), a community-based organization that specializes in family engagement to assist with this effort. HCAN provided technical support and assisted FHSD with the following tasks: 1) completed an inventory of programs where family and consumer engagement activities are being used; 2) assisted Title V leadership to review the informational materials from AMCHP and the MCH Bureau; 3) provided assistance in developing realistic and achievable strategies and outcomes to advance family and consumer engagement; and 4) maintained the Parent Leadership Training Institute, an evidence based program designed to cultivate parents as leaders and advocates for their children.

Each of the Title V Priority Area Leaders completed a survey of their family and consumer engagement activities, with wide ranging results. In some cases, activities were progressing with positive results; in other cases, programs are incorporating family engagement activities, but are unaware that those activities may qualify as "family engagement." Overall, the inventory revealed a need for training and technical support to establish a common understanding of family engagement, shared methodologies, and coordination of activities across programs.

The potential for family engagement activities among Title V programs largely depends on their structure and purpose. HCAN assisted FHSD to identify three categories of programs that have distinctly different challenges and opportunities for family and consumer engagement:

- *Direct service programs* (Children with Special Health Needs Branch, WIC) - Direct service programs provide the greatest opportunities to engage families and consumers at higher levels of involvement in policy and advocacy. FHSD staff have direct contact with parents and this provides them the opportunity to develop relationships of trust necessary to recruit parents open to getting involved. Direct service programs also have a defined population to solicit perspectives and feedback on program improvements through satisfaction surveys.

- *Population health programs that work on the systems level* (Telehealth, Oral Health Program, Safe Sleep, Reproductive Life Planning, Breastfeeding, Child Abuse and Neglect Prevention, Adolescent Health) - Programs that address systems change to improve population health have little, if any, direct contact with families and consumers. For these programs, family engagement activities have the potential to inform the development, monitoring, and quality improvement of systems and policies. Gathering information on the

priorities and perspectives of families and consumers is especially important in the State of Hawaii where there are diverse perspectives among the different ethnic and cultural groups, and communities spread across seven inhabited islands with distinctly different needs and resources. Family and consumer engagement methods to solicit perspectives and feedback include focus groups, key informant interviews, convenience surveys, polls, and consumer satisfaction surveys. These methodologies have the potential to provide FHSD staff with valuable information about the quality and impact of the services they provide.

- *Programs that contract with community based organizations to provide direct services* (Developmental Screenings, Breastfeeding, WIC) - Programs that contract with direct service organizations could promote, or in some cases, require family engagement activities. For example, contractors are frequently required to administer a consumer satisfaction survey. Not only is this a method for FHSD to monitor the quality of the services provided by contractors, but also an opportunity to solicit feedback and perspectives of the families and consumers they serve.

Other areas where the Department is looking at family engagement is through the *Ohana Nui* and Parent Leadership Training Institute. While these are larger statewide efforts, the benefit to engaging families will also help with both individual and population health.

- ***Parent Leadership Training Institute (PLTI)*** – FHSD engaged HCAN to provide the PLTI evidence-based leadership curriculum and is currently working to recruit a second cohort of PLTI participants. HCAN will also develop a network of PLTI graduates. This network of parents, willing to attend the 20-week civic engagement training, will provide a valuable resource as FHSD develops its Family and Consumer Engagement Program. They will potentially be able to assist with recruiting families and consumers to be involved in advisory board opportunities, act as a parent representative at events, and organizing families and consumers in their community to advance issues or provide perspectives on FHSD initiatives.

- ***Ohana Nui*** – The Directors of the Department of Health and Department of Human Services worked with the ASPEN Institute to study a Two-Generation model, and adopted the *Ohana Nui* ("Extended Family") approach for the generational aspects of engaging with families. FHSD recognizes the culturally appropriate need to address multi-generation families in Hawaii and include them as family and consumer partners.

II.F.4. Health Reform

Since 2015, Hawaii switched to a federally-run health exchange, Healthcare.gov after experiencing difficulty sustaining the Hawaii-based exchange. Two insurers offer plans in the Hawaii exchange in 2017: Kaiser, 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 31. 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 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 2016—an 18% increase.

With enrollments through the ACA, US census data found that the uninsured rate for Hawaii dropped 5.3% in 2014 to 6.7%. Hawaii's uninsured rate has long been lower than the US 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.

With the uncertainty around the future of the ACA, Hawaii lawmakers passed legislation (H.B.552) that will create a working group to recommend ways the state can preserve the ACA's consumer protections, regardless of federal action. The legislation states that "*the purpose of this Act is to mitigate the potential damage to the State, its residents, and its health care system that* is *likely to occur if the Affordable Care Act is repealed by an act of Congress.* Specifically, this Act establishes the affordable health insurance working group to address the complexities of the health care system in Hawaii and the related uncertainty over the future of the Affordable Care Act and to ensure that certain benefits of the Affordable Care Act remain available to Hawaii residents under state law."

The Governor signed Act 43 in June 2017. The working group will address and make recommendations related to:

(1) Minimum standard coverage requirements for individuals;
(2) Essential health care benefits;
(3) Rate setting;
(4) Medicaid expansion;
(5) Financial requirements and financing options; and
(6) Other issues that may arise, pursuant to the discretion of the working group.

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 primary role in ACA is working with stakeholders to clarify the expanded preventive benefits under ACA, inform consumers and service providers, and assure access to care. The Title V Office of Primary Care and Rural Health was instrumental in providing support for small rural critical access hospitals to complete community health needs assessments. Although smaller hospitals are not required to conducts the assessments under ACA, OPCRH helped secure technical assistance, training, and facilitation for community meetings, quantitative and qualitative data collection, and completion of final reports. These assessments also helped to inform Title V MCH priorities.

II.F.5. Emerging Issues

ZIKA VIRUS INFECTION

For the period 2015 to 5/31/17, Hawaii had 17 travel-related Zika virus cases who were infected outside of Hawaii. No cases were acquired locally. No congenital cases of Zika virus have been identified during the same period. 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.

Continuing Hawaii State Department of Health (DOH) response protocols/activities:

- Report of a suspect case triggers a case investigation by the Disease Outbreak and Control Division (DOCD)/Disease Investigation Branch and a request for Vector Control to assess the case residence. DOCD aggressively investigates all reported cases of Zika to reduce the possibility of the disease spreading in Hawaii.
- Zika testing is performed at the State Laboratories Division. Additional resources have been provided by the CDC for the State Laboratory to do antibody testing with additional antibody testing performed at the CDC.
- Once confirmed, cases are reported to CDC's ArboNET.
- DOCD is the lead for the U.S. Zika Pregnancy Registry efforts. DOCD gathers and provides information (without identifiers) to the U.S. Zika Pregnancy Registry. States have been asked to monitor Zika-infected pregnant women through their pregnancy and their infants through the first year of life.
- Medical advisories to health care providers have included clinical updates, clinician guidance on testing and patient care and counseling, and testing for Zika virus.

DOCD continues to be the lead for the Hawaii DOH Zika Virus Coordinating Team, which includes representation from the Family Health Services Division (FHSD), State Laboratory Division, Communicable Disease and Public Health Nursing Division, Harm Reduction Services Branch (Sexually Transmitted Disease Prevention and Education Programs), epidemiologists from various DOH divisions, and the DOH Communications Office. The DOH collaborative effort is working to address identification of cases, prevention, education, surveillance, timely data collection, information dissemination, and coordination of efforts around the possible risks for adverse outcomes associated with Zika virus infection.

FHSD coordination and activities:

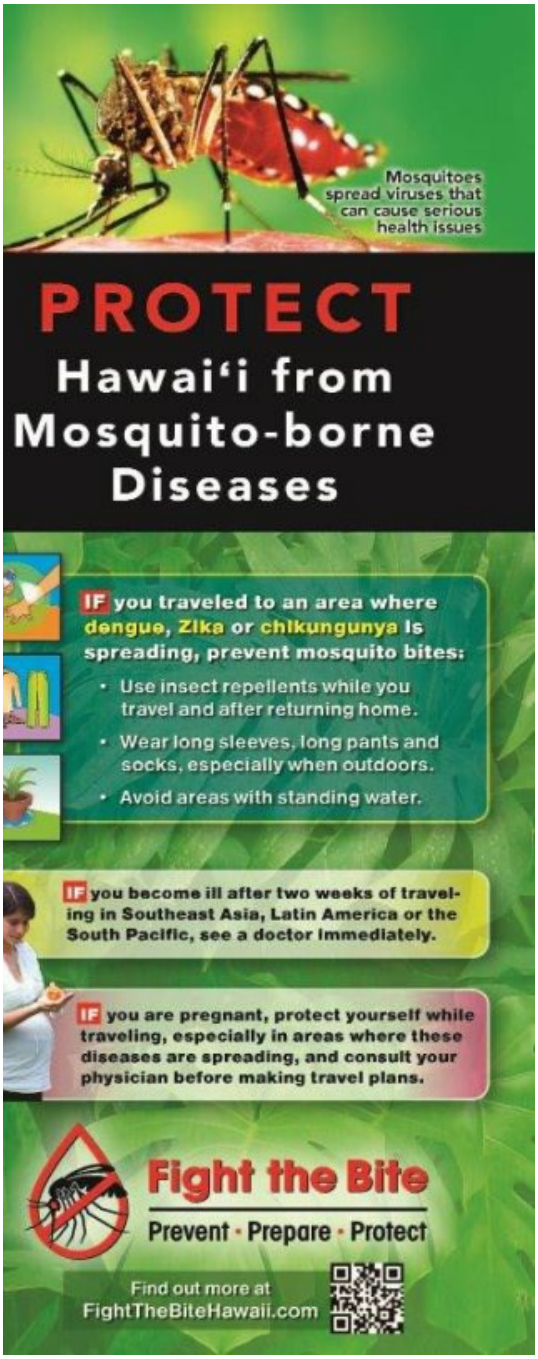
- Genomics Section continues to be the lead in coordinating Zika activities within FHSD. Pertinent FHSD programs include the CSHNB/Genomics Section (Hawaii Birth Defects Program, Newborn Metabolic Screening Program, Newborn Hearing Screening Program, Genetics Program), Children and Youth with Special Health Needs Section, and Early Intervention Section; Maternal and Child Health Branch (Family Planning, Perinatal Support Services, Home Visiting); WIC Services Branch; and Family Health Services offices within the District Health Offices for Hawaii, Maui, and Kauai counties. Areas for FHSD coordination include:

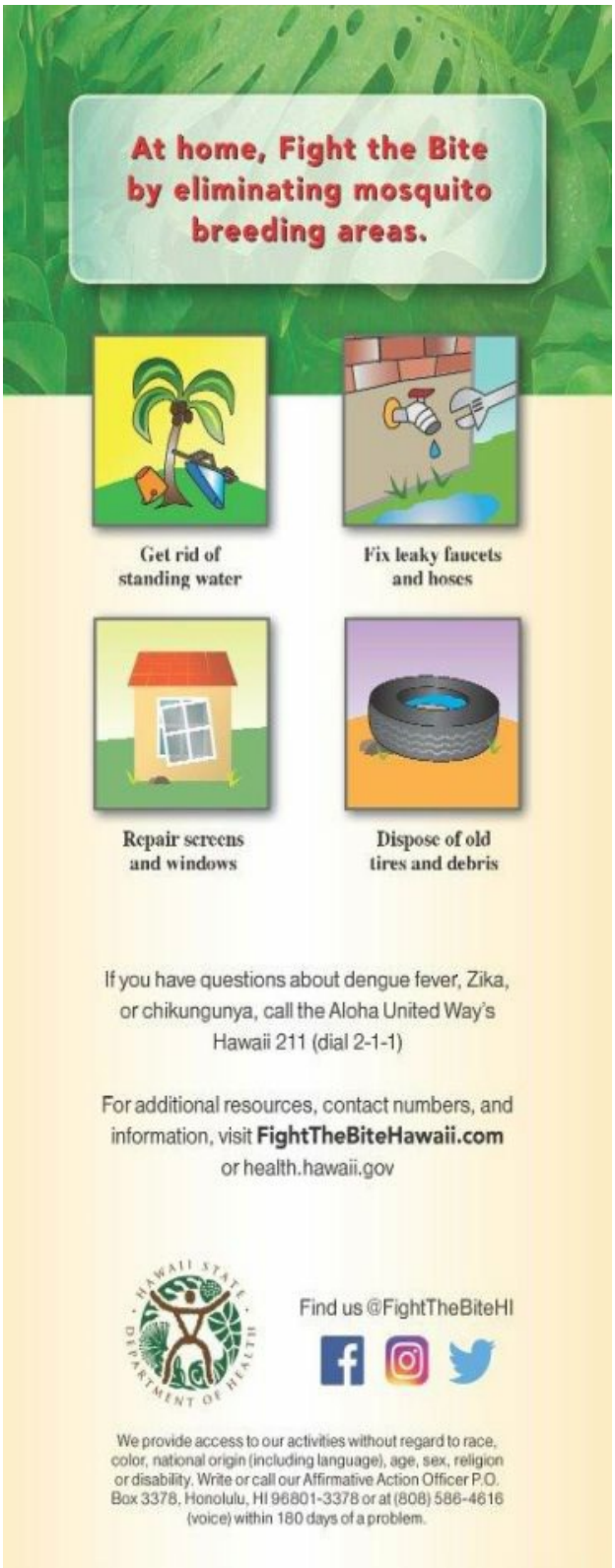
    - Input to the Communications Office on draft materials for the media campaign, and getting updates on the Zika media campaign.
    - Collaboration with DOCD/Communications Office on developing materials for family planning and pregnant women.

- Dissemination of Zika informational materials.
- Coordinating FHSD program websites (MCHB/WIC/CSHNB) so that they are linked to the DOCD Zika website (http://health.hawaii.gov/docd/dib/disease/zika_virus/) and have consistent messaging and current information.

- The Hawaii Birth Defects Program (HBDP) continues to work with the state birthing facilities to get timely reporting of babies born with microcephaly or other central nervous system defects. The HBDP abstracts the medical record information about the reported babies and reports possible cases to the CDC Zika Birth Defects Registry. The HBDP refers the abstracted cases to the DOCD for investigation of possible maternal Zika infection. Information about cases are entered into the Zika Pregnancy Registry in collaboration with the DOCD.
- The Early Intervention Section (EIS) provides early intervention services for children with microcephaly related to Zika.
- The Genomics Section received the CDC 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 HBDP to engage in surveillance, collaboration, and data utilization activities described above. The Genomics Section will also be helping link providers and families with or at risk for birth defects to available resources and services.

The statewide multi-media campaign continues. The campaign includes television commercial spots, radio advertisements including ethnic media, mall/shopping center advertisements, airport banners, general brochure about mosquito borne diseases, Fight the Bite rack card about protecting Hawaii from mosquito-borne diseases, Fight the Bite website http://fightthebitehawaii.com/, bus placards, infographics, community outreach, educator and school/community toolkits, and social media.

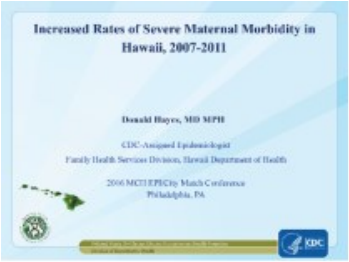

Mosquitoes spread viruses that can cause serious health issues
PROTECT
Hawai'i from Mosquito-borne Diseases
IF you traveled to an area where dengue, Zika or chikungunya is spreading, prevent mosquito bites:
• Use insect repellents while you travel and after returning home.
• Wear long sleeves, long pants and socks, especially when outdoors.
• Avoid areas with standing water.
IF you become ill after two weeks of traveling in Southeast Asia, Latin America or the South Pacific, see a doctor immediately.
IF you are pregnant, protect yourself while traveling, especially in areas where these diseases are spreading, and consult your physician before making travel plans.
Fight the Bite
Prevent · Prepare · Protect
Find out more at FightTheBiteHawaii.com


At home, Fight the Bite by eliminating mosquito breeding areas.
Get rid of standing water
Fix leaky faucets and hoses
Repair screens and windows
Dispose of old tires and debris
If you have questions about dengue fever, Zika, or chikungunya, call the Aloha United Way's Hawaii 211 (dial 2-1-1)
For additional resources, contact numbers, and information, visit FightTheBiteHawaii.com or health.hawaii.gov
HAWAII STATE DEPARTMENT OF HEALTH
Find us @FightTheBiteHI
We provide access to our activities without regard to race, color, national origin (including language), age, sex, religion or disability. Write or call our Affirmative Action Officer P.O. Box 3378, Honolulu, HI 96801-3378 or at (808) 586-4616 (voice) within 180 days of a problem.

II.F.6. Public Input

Family Health Services Division (FHSD) involves communities, stakeholders, and program participants, including families, in policy and program decision-making at many levels. Public input regarding the Title V MCH Block grant and the associated performance and strategy measures is incorporated as a continuous process throughout the year.

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 priority issue leaders continue to reachout and solicit input from partners around the state for each of the identified priorities utilizing a number of user-friendly products included in the Section V. Supporting Documents. These include a summary of the 5-year plan.

The Title V 2015 Report and 2017 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/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 2017, FHSD will post the final Title V application on the DOH website

Users find the on-line access to the grant very convenient and comments throughout the year can be submitted through a return email function on the website. While the site received 879 hits, no specific comments were received. However, inquiries were received about accessing copies of the report.

In preparation for the annual in-state Title V grant review, over 40 MCH agency/program partners and stakeholders are invited to attend the review. A link to the Title V report website is provided in the formal invitation letter. Attendees regularly include the March of Dimes, Healthy Mothers, Healthy Babies, American Academy of

Pediatrics, American College of Obstetricians and Gynecologists, Native Hawaiian Health Systems, University Medical School and School of Nursing/Dental Hygiene, Executive Office on Early Learning, Family Voices, Developmental Disabilities Council, the State Medicaid Director, Child Welfare Services, and the Attorney General's Office. Attendees from the DOH include Injury Prevention, Immunization Branch, Office of Planning and Policy Development, Neighbor Island District Health Offices, Child & Adolescent Mental Health, Vital Statistics, Administrative Services Office, and the Chronic Disease Prevention Branch. Many stakeholders attend the initial presentation of the block grant to the MCH Bureau and a several remain through the day-long review. Partners participate in the Review occasionally offering brief comments during introductions or responding to grant reviewer questions.

Utilizing AMCHP Data Translation Technical Assistance, new Title V fact sheets were developed for sharing with stakeholders and to collect public input (see Section V Supporting Documents). These included:

- Title V Update on Priorities for Maternal and Child Health (6-24-17), with information on update of measures and activities for Hawaii Title V priorities and strategies, and information and data on the priorities.
- Title V Update on Priorities (2-25-17) which shows the priority goals across the domains and updates on the priorities.
- Online survey at https://www.surveymonkey.com/r/2017_CCC-6-24-17. The survey asks parents about the age of their child/grandchild and which priorities and FHSD programs they may be interested. It also asks for their feedback on how they would like information shared with them – presentations, handouts or brochures, verbal or data updates and other suggestions. Of the 40 surveys that were distributed, 24 were completed and most were interested in the transition to adulthood for children with special health needs, child abuse and neglect, and developmental screening. 16 parents were interested in receiving short presentations or handouts and brochures although two suggested information by email.

In addition, a summary of the Hawaii 5-year plan was shared with and well received by 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.

In FFY 2017, all the Title V issue leaders developed detailed work plans for their strategy measures. The plans include identification of resources including key partners/stakeholders who share the same goals or interests. Several of the issue leaders shared the work plans with stakeholders, including families, for initial feedback. FFY 2017-2018 will be used to finalize, format the work plans for greater public review and input.

FHSD staff utilized the materials to present information at various meetings, conferences, and events on Title V block grant and priorities throughout the year. FHSD staff regularly provide updates at the Community Children's Council Co-Chair meeting with parent and professional co-chairs from all islands and Healthy Child Care Hawaii meetings. Many of the Title V priorities are included in the Department of Health (DOH) Strategic Plan 2015-18 in the focus areas of *Invest in Healthy Babies and Families* and telehealth is included in *Take Health to Where People Live, Work, Learn, and Play*.

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, Maui Early Childhood Conference and State Early Childhood Symposium.

Public and stakeholder input his 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 4 Breastfeeding: a Breastfeeding Strategic Planning Workgroup provided comments on the data around 'ever breastfed' and 'exclusively breastfed through 6 months'. There was a concern that the messaging had to be done in a sensitive way to support all mothers and families who are breastfeeding. The group had many discussions around the priority of reducing the rate of infant mortality, which sounds more depressing than the outcome of promoting breastfeeding. These concerns are documented in the strategic planning efforts as well as will be used in future messaging work on breastfeeding.

- NPM 5 Safe Sleep: at the annual Children and Youth Day, event parents were asked safe sleep related questions. The results indicated that while parents were aware that babies should be placed to sleep on their backs or use a crib, parents continued to use/include soft bedding (blankets, pillows, bumper pads, stuffed animals) or chose to sleep with their babies. The information is being used to develop messaging for a public awareness program.

- NPM 6 Developmental Screening: Providers at the Maui Early Childhood conference asked about the developmental screening resources for children who may not be eligible for Early Intervention services. The conference attendees noted that the screening would be the easier part of the performance measure but the true outcome for children is ensuring there is timely access to services or supports once identified. The workgroup decided to put more of an emphasis on the actual services and supports. Although the national performance measure is the screenings, the workgroup is committed to the services and supports which is reflected in the ESM work to develop a data system tracking the number of children screened, number of children referred, and number of children receiving services.

- NPM 7 Child Abuse and Neglect: There is greater recognition of the intersection of trauma due to family violence through child abuse and neglect, domestic violence, intimate partner violence, and sexual assault. These forms of abuse lead to significant trauma. Feedback from various constituent groups recognized this concern and led to the development of a second ESM 7.2 in FFY 2017 to focus on development of an integrated violence training approach.

- NPM 10 Adolescent Health: Work continues on promoting the Adolescent Resource Toolkit (ART) to help with messaging and dissemination of information on adolescent preventive services. The medical community (pediatricians from the American Academy of Pediatrics) had specific questions about their role under the implementation of Act 185 requiring students entering the 7th grade to have a physical examination. This led to efforts to provide trainings on the ART specific to the pediatric community in collaboration with the Hilopa'a Family to Family Health Information Center.

- NPM 12 Transition to Adult Care: family input resulted in a change in the targeted age to begin transition planning services. Youth and families suggested the discussion should start earlier than age 14. Thus, the priority need was changed to: Improve the percentage of youth with special heath care needs ages *12*-21 years who receive services necessary to make transition to adult health care.

- NPM 13 Oral Health for Children and Pregnant Women: The DOH Oral Health program is partnering with the

Hawaii Public Health Association Bright Smiles project (funded by Dental-QUEST foundation) to conduct focus groups to gather consumer input on oral health attitudes, practices and beliefs, targeting high risk groups including Native Hawaiians and the COFA/Micronesian community. The information from the project will be used to inform state strategic planning. DOH also partnered with Hawaii Children's Action Network to submit a grant application to HMSA Foundation (Blue Cross, Blue Shield affiliate) to conduct focus groups with families of young children. The data will be used to inform the development of a children's oral health plan.

Feedback/comments that are more specific obtained at in-person meetings and by survey included:

- The need to be aware of what is happening with the children living in homelessness and how FHSD and the priorities are addressing this population.
- Neighbor islands expressed concerns that limited access to services may present challenges for the Title V priorities.
- Questions were raised about the adolescent population and how to engage teens more in their health care (many teens do not know who their primary care doctor may be).
- Challenges as to how to integrate some of the violence prevention efforts;
- Concern about safe sleep environments, which was the leading cause of infant mortality, and how more (unlicensed) childcare providers could follow best practices.
- There remains confusion over how telehealth technology can be applied to practice by both providers and consumers; need clarification whether videoconferencing is considered telehealth.
- Breastfeeding disparities needs to be addressed. Hawaii has high initiation rates but needs to look at mothers who have lower rates of breastfeeding success – under age 20, Native Hawaiian or Pacific Islanders. Need to also be aware of vulnerable populations and cultural practices.

These comments were shared with the Title V Priority Issue leaders and will be addressed in FFY 2017-2018 in efforts to improve communications and engaging stakeholders.

II.F.7. Technical Assistance

Title V staff have taken advantage of various Maternal Child Health (MCH) Bureau and Association of Maternal and Child Health Programs (AMCHP) technical assistance (TA) opportunities. These opportunities not only develop staff capacity but also provide an opportunity to share Hawaii issues with other states and national centers. TA has included:

- MCH Workforce Development Center: Hawaii was part of the first cohort to receive intensive TA on developmental screening. The Hawaii team learned the use of process maps and continuous quality improvement and shared these tools with other Title V staff. The group produced developmental screening process maps five settings (home visiting, community-based screeners, EIS, a Kaiser Permanente Clinic, a pediatrician's office) which are still being used today.
- MCH Bureau/AMCHP Title V TA Working Meeting (April 2016): A Hawaii team received TA and had the opportunity to learn from other states.
- Developing Title V evidence-based/-informed strategy measures: In 2016, Hawaii utilized TA from Johns Hopkins University Strengthen the Evidence Base for MCH Programs, Got Transition, and MCH Bureau Learning Labs.
- AMCHP Data Translation: MCH Data Communications Partnerships TA project (May to December 2016) helped the Hawaii Title V team learn from communications experts to better communicate and craft messages to different audiences and techniques to present data using info graphics and Excel. The TA has been used to develop products to share Title V information with stakeholders to collect public input. See examples in Section V. Supporting documents.
- MCH Bureau's State/Federal Maternal and Child Health Partnership Technical Assistance Meeting (December 12-14, 2016, Arlington, VA)
- AMCHP Data Linkage: Phase I–MCH and Medicaid Data Partnerships TA project (May 2016 to October 2017) to create data sharing partnerships between public health MCH programs and Medicaid. The project has consisted of conference calls with AMCHP staff and subject matter experts to discuss Hawaii's barriers. To date, legal restrictions on the sharing of Medicaid data outside of a Medicaid agency have been the primary barrier to establishing a data sharing agreement. Moving forward, the Hawaii team will continue to attempt to explore solutions to legal barriers and work with the AMCHP team to identify opportunities for progress.

The Title V agency, FHSD, has been partnering with the MCH LEND program to provide TA and training for the Title V Leadership team that includes program staff serving as lead for the national and state priority issues.

The Title V Leadership Team will be meeting with MCH LEND to identify further areas for assistance including training on family engagement and partnership development. Title V will help shape the topics, assist with trainings, and share information needed to assure progress on the priorities. Training resources will help to inform the development and monitoring of the Title V 5-year plan strategies and activities. The program will assure integration and application of science-based practices, quality improvement techniques, and systems approaches to effectively improve health outcomes. If additional TA is required, a TA request will be considered.

Hawaii is considering conducting a Title V meeting for the agency staff and key stakeholders. The meetings, once held annually, includes both clerical and administrative staff. The meetings are used to increase understanding of the MCH field, encourage greater collaboration/coordination across the agency's 28 programs and neighbor island units, provide important national and departmental updates, highlight the good work of the agency, and collect input for areas for improvement. While FHSD annually convenes program staff for Title V updates, a large meeting with all staff has not been held in three years largely because of the key vacancies at the Division level. A TA request may be submitted to host a national keynote speaker.

III. Budget Narrative

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,024,653	$1,486,740	$2,144,047	$1,390,506
Unobligated Balance	$0	$332,197	$228,563	$670,258
State Funds	$25,296,742	$23,049,391	$25,217,539	$22,376,536
Local Funds	$0	$0	$0	$0
Other Funds	$75,000	$13,760	$75,000	$6,359
Program Funds	$19,135,183	$9,924,594	$19,172,085	$11,342,262
SubTotal	$46,531,578	$34,806,682	$46,837,234	$35,785,921
Other Federal Funds	$47,260,340		$45,034,232	$0
Total	$93,791,918	$34,806,682	$91,871,466	$35,785,921

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,156,997	$1,213,952	$2,176,627	
Unobligated Balance	$422,453	$628,247	$651,223	
State Funds	$28,911,631	$26,442,167	$29,083,184	
Local Funds	$0	$0	$0	
Other Funds	$75,000	$0	$75,000	
Program Funds	$16,520,311	$12,356,042	$16,745,817	
SubTotal	$48,086,392	$40,640,408	$48,731,851	
Other Federal Funds	$54,186,151	$31,816,371	$55,420,856	
Total	$102,272,543	$72,456,779	$104,152,707	

	2018	
	Budgeted	Expended
Federal Allocation	$2,179,673	
Unobligated Balance	$817,875	
State Funds	$28,414,686	
Local Funds	$0	
Other Funds	$63,078	
Program Funds	$16,422,876	
SubTotal	$47,898,188	
Other Federal Funds	$49,970,074	
Total	$97,868,262	

III.A. Expenditures

Significant Budget Variations – Form 2 (Fiscal Year 2016)

Item 1. Federal Allocation. The estimated award for the fiscal year 2016 Title V Block Grant application was $2,156,997 however the actual amount expended for the amount awarded in fiscal year 2016 was $1,213,952. The variance is due to the $774,345.91 in unobligated Title V funds carried over into fiscal year 2016 from the fiscal year 2015 grant award.

Item 1A. Earmark for Preventive and Primary Care for Children. The amount budgeted in this category for fiscal year 2016 was $737,477, however the amount actually expended was $512,302, a difference of $225,175. This variance is primarily due to salary and fringe benefit savings due to vacancies. The Family Health Services Division ("FHSD") did not fill vacant Title V funded positions to ensure that there were sufficient funds to meet salary, fringe benefit, and operating costs in federal fiscal year 2016.

Item 1B. Earmark for Children with Special Health Care Needs. Of the $938,725 budgeted in fiscal year 2016 for this category, a sum of $376,855 was actually expended. As mentioned above, the Family Health Services Division did not fill vacant Title V funded positions to ensure that there were sufficient grant funds to meet salary, fringe benefit, and operating costs.

Item 1C. Title V Administrative Cost. The budgeted amount for this category in fiscal year 2016 was $115,511, and the actual amount expended from the fiscal year 2016 was $46,715, a difference of $68,796. This difference is due to $60,378 being expended from the fiscal year 2015 Title V award in federal fiscal year 2016 for administrative costs.

Item 2. Unobligated Balance. The actual expenditures of $628,247 for the category "Unobligated Balance" was higher than the budgeted amount of $422,453 in fiscal year 2016 due to unfilled vacant Title V funded positions. As mentioned previously, the Family Health Services Division did not fill vacant Title V funded positions to ensure that there were sufficient grant funds to meet salary, fringe benefit and operating costs.

Item 3. State Funds. The amount budgeted for the category "State Funds" was $28,911,631 in fiscal year 2016, and the amount actually expended was $26,442,167, a difference of $2,469,461. This difference is attributed to outstanding unliquidated encumbrances as of September 30, 2016.

Item 5. Other Funds. The budgeted amount for the category "Other Funds" was $75,000 in fiscal year 2016 but there were no actual expenditures due to the elimination of the Child Death Review Coordinator due to the State Department of Human Services, Social Services Division's inability to continue providing funds for this position. A request to the FY17 legislature to fund the Child Death Review Coordinator position was approved for the FY18 budget.

Item 6. Program Income. The amount budgeted for this category in fiscal year 2016 was $16,520,311 and the amount actually expended was $12,356,042. 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. Accordingly, the funds being expended annually is congruent with the revenues being deposited, and not with the authorized budget ceilings for these special fund accounts.

III.B. Budget

The State's maintenance of effort level from 1989 is $11,910,549 and the State's overmatch in fiscal year 2018 is $16,504,137. There are no continuation funding for special projects, or for special consolidated projects in fiscal year 2018.

Significant Budget Variations – Form 2 (Fiscal Year 2018)

Item 1. Federal Allocation. The "Federal Allocation" category for fiscal year 2017 amounts to $2,179,673. The Federal Allocation amount being used for the fiscal year 2018 Title V grant application is the same as the estimated Title V grant award for fiscal year 2017.

Item 1. A-C. Earmarks for Preventive and Primary Care for Children, Children with Special Health Needs, and Administrative Costs.

Item 1A. Preventive and Primary Care for Children. The amount budgeted for this category in the fiscal year 2017 grant application was $778,528, and the amount budgeted for this category in the fiscal year 2018 application is 701,684. This does not reflect a significant variation.

Item 1B. Children with Special Health Care Needs. The amount budgeted for this category in the fiscal year 2017 application was $761,805, and the amount budgeted for this category in the fiscal year 2018 application is $713,393. The decrease of $48,412 is due to recent Title V funded position vacancies in the Children with Special Health Care Needs Branch.

Item 1C. Title V Administrative Costs. The amount budgeted for this category in the fiscal year 2017 application was $191,301, and the amount budgeted for this category in the fiscal year 2018 application is $190,447. The decrease of $854 does not represent a significant variation.

Item 2. Unobligated Balance. The estimated unobligated balance from the fiscal year 2017 grant application was $774,346, and the estimated unobligated balance in fiscal year 2018 is $817,875. The increase in the estimated unobligated balance for fiscal year 2018 is due to the continuing implementation of cost savings measures. For example, vacant Title V funded positions are being left unfilled to ensure that there are sufficient grant funds to meet increases in collective bargaining and fringe benefit costs in fiscal year 2018. Collective bargaining and fringe benefit costs continue to escalate each year, however the Title V grant awards have remained at relatively the same levels in recent years.

Item 3. State MCH Funds. The category "State MCH Funds" has decreased from $29,083,184 in fiscal year 2017 to $28,414,686 in fiscal year 2018. The decrease does not represent a significant variation.

Item 6. Program Income. The category "Program Income" has slightly decreased from $16,745,817 in fiscal year 2016 to $16,422,876 in fiscal year 2018. This does not represent a significant variation.

Item 9. Other Federal Funds. The category "Other Federal Funds" has decreased from $55,420,856 in fiscal year 2017 to $49,970,074 in fiscal year 2018. The decrease of $5,450,782 is due to significant decreases in Federal funding allotted to the US Department of Agriculture Food and Nutrition Services for the Women, Infants and Children (WIC) Branch and also the Maternal, Infant and Early Childhood Home Visiting Program.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - DHS-DOH Medicaid MOA 6-8-15.pdf

V. Supporting Documents

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

Supporting Document #01 - Buckets-wkplans.pdf

Supporting Document #02 - Data Collection Forms.pdf

Supporting Document #03 - GLOSSARY OF TERMS.pdf

Supporting Document #04 - Public-input.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Hawaii

	FY18 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,179,673	
A. Preventive and Primary Care for Children	$ 701,684	(32.1%)
B. Children with Special Health Care Needs	$ 713,393	(32.7%)
C. Title V Administrative Costs	$ 190,447	(8.8%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 817,875	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 28,414,686	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 63,078	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 16,422,876	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 44,900,640	
A. Your State's FY 1989 Maintenance of Effort Amount $ 11,910,549		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 47,898,188	
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	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 97,868,262	

OTHER FEDERAL FUNDS	FY18 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Program (CBCAP)	$ 454,196
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 28,461,369
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)	$ 426,000
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) > Rape Prevention and Education (RPE) Program	$ 255,086
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 40,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 250,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 191,116
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 575,300
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
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
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 143,825
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 192,669
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,157,300

OTHER FEDERAL FUNDS	FY18 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Health	$ 172,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	$ 167,994
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Medicare Rural Hospitality Flexibility Program	$ 419,316
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospital Improvement Program	$ 90,000

	FY16 Annual Report Budgeted		FY16 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,156,997		$ 1,213,952	
A. Preventive and Primary Care for Children	$ 737,477	(34.2%)	$ 512,302	(42.2%)
B. Children with Special Health Care Needs	$ 938,725	(43.5%)	$ 376,855	(31%)
C. Title V Administrative Costs	$ 115,511	(5.4%)	$ 46,715	(3.9%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 422,453		$ 628,247	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 28,911,631		$ 26,442,167	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 75,000		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 16,520,311		$ 12,356,042	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 45,506,942		$ 38,798,209	
A. Your State's FY 1989 Maintenance of Effort Amount $ 11,910,549				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 48,086,392		$ 40,640,408	
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)	$ 54,186,151		$ 31,816,371	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 102,272,543		$ 72,456,779	

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Program (CBCAP)	$ 317,933	$ 244,546
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000	$ 155,531
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 156,881	$ 106,191
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Basic Screening Survey (BSS)	$ 230,000	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 144,078	$ 44,494
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 40,000	$ 27,268
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 255,086	$ 198,802
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 9,430,783	$ 3,753,333
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 157,402	$ 144,245
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Genetic Services Project	$ 600,000	$ 487,075
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 95,374	$ 105,568
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 12,328

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,157,300	$ 2,157,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 37,081,166	$ 21,655,816
US Department of Education > Office of Special Education Programs > Early Identification and Intervention Infants/Toddlers	$ 2,148,926	$ 2,140,004
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program		$ 74,418
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Office of Rura	$ 185,737	$ 17,158
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Hospital Flexi	$ 406,000	$ 238,305
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospita	$ 111,491	$ 100,610
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care O	$ 167,994	$ 153,679

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: The “Federal Allocation” category for fiscal year 2017 amounts to $2,179,673. The Federal Allocation amount being used for the fiscal year 2018 Title V grant application is the same as the estimated Title V grant award for fiscal year 2017.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: The amount budgeted for this category in the fiscal year 2017 grant application was $778,528, and the amount budgeted for this category in the fiscal year 2018 application is 701,684. This does not reflect a significant variation.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: The amount budgeted for this category in the fiscal year 2017 application was $761,805, and the amount budgeted for this category in the fiscal year 2018 application is $713,393. The decrease of $48,412 is due to recent Title V funded position vacancies in the Children with Special Health Care Needs Branch.	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: The amount budgeted for this category in the fiscal year 2017 application was $191,301, and the amount budgeted for this category in the fiscal year 2018 application is $190,447. The decrease of $854 does not represent a significant variation.	
5.	**Field Name:**	**2. UNOBLIGATED BALANCE**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**

Field Note:
The estimated unobligated balance from the fiscal year 2017 grant application was $774,346, and the estimated unobligated balance in fiscal year 2018 is $817,875. The increase in the estimated unobligated balance for fiscal year 2018 is due to the continuing implementation of cost savings measures. For example, vacant Title V funded positions are being left unfilled to ensure that there are sufficient grant funds to meet increases in collective bargaining and fringe benefit costs in fiscal year 2018. Collective bargaining and fringe benefit costs continue to escalate each year, however the Title V grant awards have remained at relatively the same levels in recent years.

6.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**

Field Note:
The category “State MCH Funds” has decreased from $29,083,184 in fiscal year 2017 to $28,414,686 in fiscal year 2018. The decrease does not represent a significant variation.

7.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**

Field Note:
The category “Program Income” has slightly decreased from $16,745,817 in fiscal year 2016 to $16,422,876 in fiscal year 2018. This does not represent a significant variation.

8.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**

Field Note:
The estimated award for the fiscal year 2016 Title V Block Grant application was $2,156,997 however the actual amount expended for the amount awarded in fiscal year 2016 was $1,213,952. The variance is due to the $774,345.91 in unobligated Title V funds carried over into fiscal year 2016 from the fiscal year 2015 grant award.

9.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**

Field Note:
The amount budgeted in this category for fiscal year 2016 was $737,477, however the amount actually expended was $512,302, a difference of $225,175. This variance is primarily due to salary and fringe benefit savings due to vacancies. The Family Health Services Division (“FHSD”) did not fill vacant Title V funded positions to ensure that there were sufficient funds to meet salary, fringe benefit, and operating costs in federal fiscal year 2016.

10.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2016**

	Column Name:	**Annual Report Expended**
	Field Note: Of the $938,725 budgeted in fiscal year 2016 for this category, a sum of $376,855 was actually expended. As mentioned above, the Family Health Services Division did not fill vacant Title V funded positions to ensure that there were sufficient grant funds to meet salary, fringe benefit, and operating costs.	
11.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: The budgeted amount for this category in fiscal year 2016 was $115,511, and the actual amount expended from the fiscal year 2016 was $46,715, a difference of $68,796. This difference is due to $60,378 being expended from the fiscal year 2015 Title V award in federal fiscal year 2016 for administrative costs.	
12.	**Field Name:**	**2. UNOBLIGATED BALANCE**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: The actual expenditures of $628,247 for the category “Unobligated Balance” was higher than the budgeted amount of $422,453 in fiscal year 2016 due to unfilled vacant Title V funded positions. As mentioned previously, the Family Health Services Division did not fill vacant Title V funded positions to ensure that there were sufficient grant funds to meet salary, fringe benefit and operating costs.	
13.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: The amount budgeted for the category “State Funds” was $28,911,631 in fiscal year 2016, and the amount actually expended was $26,442,167, a difference of $2,469,461. This difference is attributed to outstanding unliquidated encumbrances as of September 30, 2016.	
14.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: The budgeted amount for the category “Other Funds” was $75,000 in fiscal year 2016 but there were no actual expenditures due to the elimination of the Child Death Review Coordinator due to the State Department of Human Services, Social Services Division’s inability to continue providing funds for this position. A request to the FY17 legislature to fund the Child Death Review Coordinator position was approved for the FY18 budget.	
15.	**Field Name:**	**6. PROGRAM INCOME**

	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: The amount budgeted for this category in fiscal year 2016 was $16,520,311 and the amount actually expended was $12,356,042. 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. Accordingly, the funds being expended annually is congruent with the revenues being deposited, and not with the authorized budget ceilings for these special fund accounts.	
16.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Basic Screening Survey (BSS)**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Wrong program entered for FY16. Expended amount listed under State Oral Disease Prevention Program.	
17.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Budgeted amount is $230,000. In FY16 incorrectly listed as Basic Screening Survey.	

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	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 532,111	$ 236,042
2. Infants < 1 year	$ 42,038	$ 42,038
3. Children 1-22 years	$ 701,684	$ 512,302
4. CSHCN	$ 713,393	$ 376,855
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 1,989,226	$ 1,167,237

IB. Non Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 4,607,758	$ 3,025,447
2. Infants < 1 year	$ 3,943,050	$ 3,475,058
3. Children 1-22 years	$ 9,489,012	$ 6,505,399
4. CSHCN	$ 21,438,863	$ 18,625,317
5. All Others	$ 6,988,431	$ 5,506,974
Non Federal Total of Individuals Served	$ 46,467,114	$ 37,138,195
Federal State MCH Block Grant Partnership Total	$ 48,456,340	$ 38,305,432

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Form 3b
Budget and Expenditure Details by Types of Services

State: Hawaii

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 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	$ 472,493	$ 187,174
3. Public Health Services and Systems	$ 1,707,180	$ 1,026,778
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	$ 2,179,673	$ 1,213,952

IIB. Non-Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 19,692,852	$ 16,269,174
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 2,698,849	$ 1,531,782
B. Preventive and Primary Care Services for Children	$ 5,496,715	$ 4,345,536
C. Services for CSHCN	$ 11,497,288	$ 10,391,856
2. Enabling Services	$ 11,907,917	$ 10,205,239
3. Public Health Services and Systems	$ 9,724,680	$ 7,457,728
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		$ 1,555,040
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 1,130,690
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Primary and Urgent Care in Hana, Hawaii		$ 941,668
Waianae Coast Emergency Rooms Services		$ 1,468,000
Early Intervention Services (POS)		$ 11,173,776
Direct Services Line 4 Expended Total		$ 16,269,174
Non-Federal Total	$ 41,325,449	$ 33,932,141

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. - 1. Direct Services**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: It should be noted that Form 3b does not include a category for “All Others” under Direct Services. Accordingly, the budget for fiscal year 2018 and the expenditures for fiscal year 2016 does not provide a complete snapshot of all direct services provided by the Family Health Services Division.	
2.	**Field Name:**	**IIA. - 1. Direct Services**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: It should be noted that Form 3b does not include a category for “All Others” under Direct Services. Accordingly, the budget for fiscal year 2018 and the expenditures for fiscal year 2016 does not provide a complete snapshot of all direct services provided by the Family Health Services Division.	

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

State: Hawaii

Total Births by Occurrence: 18,062

1. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	17,937 (99.3%)	973	35	35 (100.0%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (cobalamin disorders)	3-Hydroxy-3-methyglutaric aciduria	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect
Medium-chain acyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria
Citrullinemia, type I	Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I
Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S, βeta-thalassemia	S,C disease
Biotinidase deficiency	Critical congenital heart disease	Cystic fibrosis	Hearing loss	Severe combined immunodeficiences
Classic galactosemia	Adrenoleukodystrophy	Mucopolysaccharidosis, type I	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Isovaleric acidemia
3-Methylcrotonyl-CoA carboxylase deficiency	Holocarboxylase synthase deficiency	ß-Ketothiolase deficiency		

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 5a
Unduplicated Count of Individuals Served under Title V

State: Hawaii

Reporting Year 2016

		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	999	71.3	0.0	12.8	10.9	5.0
2. Infants < 1 Year of Age	1,237	0.0	0.0	100.0	0.0	0.0
3. Children 1 to 22 Years of Age	3,714	0.0	0.0	100.0	0.0	0.0
4. Children with Special Health Care Needs	7,545	43.2	0.0	37.2	0.7	18.9
5. Others	0					
Total	13,495					

Form Notes for Form 5a:

Data reported for Form 5a are from the state funded portions of the following programs: Primary Care Contracts, Perinatal Support Services, CSHNP, and neighbor island (Hawaii).

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2016**
	Field Note: Programs that contributed to this count include pregnant women who received Perinantal Support Services (949) and Hawai'i (Big Island) District Health Office (50).	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2016**
	Field Note: Programs that contributed to this count of infants include 2015 Primary Care Contracts, which are state funded for safety net providers including Federally Qualified Health Centers to provide services for the uninsured/underinsured. Due to personnel change, the count for 2016 primary care contracts is not available.	
3.	**Field Name:**	**Children 1 to 22 Years of Age**
	Fiscal Year:	**2016**
	Field Note: Programs that contributed to this count of children 1-22 years of age include 2015 Primary Care Contracts, which are state funded for safety net providers including Federally Qualified Health Centers to provide services for the uninsured/underinsured. Due to personnel change, the count for 2016 primary care contracts is not available.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2016**
	Field Note: 2016 data for the number of children serviced contributed by CSHNP (7,475) and Maui District Health Office (70).	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2016**
	Field Note: None for form 5a	

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Hawaii

Reporting Year 2016

Types Of Individuals Served	Total Served
1. Pregnant Women	18,250
2. Infants < 1 Year of Age	18,154
3. Children 1 to 22 Years of Age	394,877
4. Children with Special Health Care Needs	35,022
5. Others	156,045
Total	622,348

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2016**
	Field Note: Estimates based on total number of births in calendar year 2016 (18,062), pregnant women served by Home Visiting program (38) and by state funded FHSD nurses located in Hawaii/Big Island District Health Office (150).	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2016**
	Field Note: Estimates based on number of newborns screened in FY 2016 (17,937), infants served by the Home Visiting program (172) and by the Family Strengthening programs: Parent line (44) and Home Reach (1).	
3.	**Field Name:**	**Children 1 to 22 Year of Age**
	Fiscal Year:	**2016**
	Field Note: Based on 2010 Census Estimate. Single year age group is not provided since 2010.	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2016**
	Field Note: Based on 2015 number of special health care needs children served by CSHNB. 2016 data was not available yet.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2016**
	Field Note: Based on 2010 Census Estimate. Single year age group is not provided since 2010.	

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Hawaii

Reporting Year 2016

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	18,062	4,646	451	10	4,596	1,742	6,444	173
Title V Served	17,934	4,613	447	10	4,563	1,730	6,399	172
Eligible for Title XIX	7,753	1,077	119	126	2,438	2,116	0	1,877
2. Total Infants in State	11,181	1,032	220	0	3,949	5,980	0	0
Title V Served	11,102	1,025	218	0	3,921	5,938	0	0
Eligible for Title XIX	9,474	153	44	32	393	165	0	8,687

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	15,249	2,777	36	18,062
Title V Served	15,142	2,757	35	17,934
Eligible for Title XIX	0	0	7,753	7,753
2. Total Infants in State	8,738	2,443	0	11,181
Title V Served	8,676	2,426	0	11,102
Eligible for Title XIX	0	0	9,474	9,474

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Information obtained from maternal race as reported in 2016 vital statistics birth certificate data. Not limited to Hawaii residents as identifying information is no longer provided by Vital Statistics. Note: Part II Unduplicated Count by Ethnicity, total Hispanic or Latino is obtained from the mother's Spanish Origin by Vital Statistics data	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Used overall estimate of newborn metabolic screening percentage (99.3%) in 2016 applied to overall total and each race group.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Data source: Data from Hawaii Medicaid program in 2016 and reflects unduplicated clients served. 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. Note: Data on ethnicity was not provided by the Hawaii Medicaid Program.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Latest data available from Hawaii Health Survey is 2012. Number of infants is based on those under 1 year of age. 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:	**2016**
	Column Name:	**Total All Races**
	Field Note: Based on the proportion of infants receiving newborn metabolic screening (99.3% in 2016)	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Data source: Data from Hawaii Medicate program from 2016 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	2018 Application Year	2016 Reporting 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"	Retchel Oyao	Retchel Oyao
4. Contact Person's Telephone Number	(808) 681-1421	(808) 681-1421
5. Number of Calls Received on the State MCH "Hotline"		2,781

B. Other Appropriate Methods	2018 Application Year	2016 Reporting Year
1. Other Toll-Free "Hotline" Names	Early Intervention Referral Line	Early Intervention Referral Line
2. Number of Calls on Other Toll-Free "Hotlines"		3,418
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		879
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 Ave
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 2018

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 and pregnant women.
7.	Improve the healthy development, health, safety, and well-being of adolescents
8.	Improve access to services through telehealth
9.	Improve family and consumer engagement in Title V Programs.
10.	Improve partner engagement in Family Health Services Division (FHSD).

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 10a
National Outcome Measures (NOMs)

State: Hawaii

Form Notes for Form 10a 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
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%, 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
2014	159.5	10.4 %	241	15,107
2013	123.2	9.0 %	191	15,504
2012	127.4	9.1 %	199	15,625
2011	101.0	8.1 %	157	15,550
2010	60.4	6.3 %	94	15,556
2009	70.3	6.7 %	111	15,797
2008	73.5	6.8 %	119	16,199

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

FAD Not Available for this measure.

State Provided Data	
	2016
Annual Indicator	22.3
Numerator	12
Denominator	53,892
Data Source	Vital Statistics
Data Source Year	2012-2016

NOM 3 - Notes:

Indicators are provided in a 5 year aggregate and reflects maternal deaths and births to mothers who were residents of Hawaii. Calculation of Maternal Death is based on WHO convention of Underlying Cause of Death, ICD10 codes of A34, O00-O95, O98-O99. 2016 data is provisional

Data Alerts: None

NOM 4.1 - 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
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	8.4 %	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%, or >10% missing data and should be interpreted with caution

NOM 4.1 - Notes:

None

Data Alerts: None

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	1.3 %	0.1 %	245	18,392
2014	1.3 %	0.1 %	243	18,526
2013	1.4 %	0.1 %	263	18,970
2012	1.2 %	0.1 %	231	18,975
2011	1.2 %	0.1 %	232	18,947
2010	1.2 %	0.1 %	222	18,972
2009	1.4 %	0.1 %	264	18,872

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.2 - Notes:

None

Data Alerts: None

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	7.0 %	0.2 %	1,286	18,392
2014	6.6 %	0.2 %	1,219	18,526
2013	6.9 %	0.2 %	1,299	18,970
2012	6.9 %	0.2 %	1,311	18,975
2011	7.0 %	0.2 %	1,325	18,947
2010	7.2 %	0.2 %	1,362	18,972
2009	7.0 %	0.2 %	1,328	18,872

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.3 - Notes:

None

Data Alerts: None

NOM 5.1 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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	11.2 %	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%, or >10% missing data and should be interpreted with caution

NOM 5.1 - Notes:

None

Data Alerts: None

NOM 5.2 - Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.7 %	0.1 %	491	18,409
2014	2.4 %	0.1 %	444	18,537
2013	2.6 %	0.1 %	498	18,959
2012	2.5 %	0.1 %	472	18,964
2011	2.6 %	0.1 %	497	18,938
2010	2.8 %	0.1 %	521	18,953
2009	2.8 %	0.1 %	529	18,785

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.2 - Notes:

None

Data Alerts: None

NOM 5.3 - Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	7.4 %	0.2 %	1,370	18,409
2014	7.7 %	0.2 %	1,418	18,537
2013	7.5 %	0.2 %	1,430	18,959
2012	7.5 %	0.2 %	1,413	18,964
2011	7.3 %	0.2 %	1,383	18,938
2010	7.7 %	0.2 %	1,464	18,953
2009	8.3 %	0.2 %	1,565	18,785

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.3 - 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
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%, 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
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
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	6.1	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
2014	4.5	0.5 %	83	18,550
2013	6.4	0.6 %	121	18,987
2012	4.9	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
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
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
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
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
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 has a confidence interval width that is inestimable or >20% 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 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	4.8	0.6 %	73	15,107
2013	3.9	0.5 %	60	15,504
2012	2.5	0.4 %	39	15,625
2011	2.3	0.4 %	36	15,550
2010	1.7	0.3 %	27	15,556
2009	1.8	0.3 %	28	15,797
2008	1.8	0.3 %	29	16,199

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

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 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.6 %	1.3 %	55,914	285,473

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% 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
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
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
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
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	9.6	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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	17.1 %	1.2 %	51,895	304,085
2007	17.9 %	1.2 %	50,137	279,867
2003	15.0 %	1.0 %	44,310	296,099

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% 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) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	22.7 %	2.1 %	7,254	31,949

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children 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
2011_2012	1.3 %	0.4 %	3,373	252,498
2007	0.6 %	0.2 %	1,416	229,332

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children 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
2011_2012	5.7 %	0.8 %	14,236	251,557
2007	4.2 %	0.7 %	9,502	228,582

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children 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
2011_2012	58.7 %	6.2 %	11,474	19,553
2007	63.0 %	6.6 %	8,602	13,660
2003	67.8 %	5.9 %	10,641	15,687

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children 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
2011_2012	86.0 %	1.1 %	261,333	303,854
2007	86.7 %	1.1 %	241,938	279,051
2003	86.7 %	1.0 %	256,361	295,749

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	27.4 %	2.0 %	36,008	131,228
2007	28.5 %	2.1 %	34,313	120,448
2003	26.9 %	1.8 %	34,448	128,172

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	24.0 %	0.4 %	3,113	12,987
2012	23.0 %	0.4 %	3,358	14,578
2010	22.3 %	0.4 %	3,237	14,504
2008	22.6 %	0.4 %	2,891	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
2015	28.3 %	1.5 %	11,069	39,140
2013	28.3 %	1.4 %	11,359	40,213
2011	26.6 %	1.7 %	11,206	42,116
2009	27.9 %	2.5 %	13,197	47,369
2007	29.2 %	1.7 %	15,200	52,142
2005	26.8 %	1.1 %	14,021	52,303

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 that is inestimable or >20% 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
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 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
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 (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	71.3 %	4.1 %	27,643	38,775
2014	60.4 %	4.4 %	23,739	39,293
2013	52.7 %	5.2 %	20,537	38,995
2012	64.6 %	4.8 %	26,054	40,328
2011	73.1 %	4.1 %	29,710	40,620
2010	62.7 %	4.8 %	24,485	39,075
2009	65.0 %	4.8 %	24,533	37,761

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

Data Source: National Immunization Survey (NIS) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	62.6 %	4.1 %	25,267	40,397
2014	56.5 %	4.4 %	23,138	40,967
2013	39.7 %	4.6 %	16,275	41,043
2012	43.1 %	4.9 %	18,123	42,050
2011	11.7 %	2.8 %	4,957	42,417

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
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
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 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: Hawaii

NPM 1 - Percent of women with a past year preventive medical visit

Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	62
Annual Indicator	63.0
Numerator	152,559
Denominator	242,088
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	63.0	64.0	64.0	65.0	65.0	66.0

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2015: 63%).

NPM 4 - A) Percent of infants who are ever breastfed

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	90
Annual Indicator	90.6
Numerator	15,214
Denominator	16,789
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	91.0	92.0	93.0	94.0	94.0	95.0

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2013: 90.6%).

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	27
Annual Indicator	30.1
Numerator	4,828
Denominator	16,071
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	27.0	27.0	27.0	28.0	28.0	28.0

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2013: 30.1%). The 2021 goal was carried forward to 2022.

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	79
Annual Indicator	79.2
Numerator	14,243
Denominator	17,975
Data Source	PRAMS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	79.0	80.0	81.0	82.0	82.0	83.0

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2013: 79.2%).

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	39
Annual Indicator	38.9
Numerator	31,440
Denominator	80,906
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	40.0	40.0	41.0	41.0	41.0	42.0

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2011-2012: 38.9%).

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Child Health)

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - CHILD	
	2016
Annual Objective	149
Annual Indicator	129.6
Numerator	231
Denominator	178,298
Data Source	SID-CHILD
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	148.0	147.0	145.0	142.0	142.0	141.0

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2014: 129.6%).

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
Annual Objective	83
Annual Indicator	82.2
Numerator	83,403
Denominator	101,416
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	83.0	84.0	85.0	86.0	86.0	86.0

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2011-2012: 82.2%). The 2021 goal was carried forward to 2022.

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	36
Annual Indicator	37.3
Numerator	4,714
Denominator	12,643
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	36.0	37.0	38.0	39.0	39.0	39.0

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2009-2010: 37.3%). The 2021 goal was carried forward to 2022.

NPM 13 - A) Percent of women who had a dental visit during pregnancy

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	38
Annual Indicator	46.8
Numerator	8,607
Denominator	18,380
Data Source	PRAMS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	40.0	41.0	42.0	45.0	45.0	49.0

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2013: 46.8%).

NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	84
Annual Indicator	83.1
Numerator	236,960
Denominator	285,187
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	84.0	85.0	86.0	87.0	87.0	87.0

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2011-2012: 83.1%). The 2021 goal was carried forward to 2022.

Form 10a
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
Annual Objective	
Annual Indicator	
Numerator	8
Denominator	72
Data Source	Telehealth work group, FHSD
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	22.0	34.0	44.0	56.0	68.0	72.0

Field Level Notes for Form 10a SPMs:

1. **Field Name:** **2017**

   Column Name: **Annual Objective**

   Field Note:
   Objectives were set by the FHSD staff considering baseline data and expected progress, considering the work plans and program changes that are needed. The FHSD staff did a baseline assessment using the Data Collection Forms for SPM 1 (form can be found in the Supporting Document) and identified a baseline of 22.

SPM 2 - The percentage of Family Health Services Division (FHSD) staff that have increased their knowledge on family/consumer engagement.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	23.9
Numerator	11
Denominator	46
Data Source	FHSD Staff Survey
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	29.0	34.0	39.0	44.0	49.0	54.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
Objectives were set by the Title V Planning Committee based on baseline data (24%), expected progress, considering the work and program changes that are needed.

SPM 3 - The percentage of Family Health Services Division (FHSD) staff that have increased their knowledge on Partner Engagement.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	13
Numerator	6
Denominator	46
Data Source	FHSD Staff survey
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	18.0	23.0	28.0	33.0	38.0	43.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
Objectives were set by the Title V Planning Committee based on baseline data (13%), expected progress, considering the work and program changes that are needed.

Form 10a
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
Annual Objective	
Annual Indicator	33.5
Numerator	3,219
Denominator	9,616
Data Source	vital statistics
Data Source Year	2015
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	34.0	34.0	35.0	35.0	35.0	35.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Estimate based on 2015 provisional vital statistics data file as final 2015 or provisional 2016 data file not available due to suppression of current infant month of birth.

The annual performance objective for years 2017-2022 reflects an approximate 5% improvement over 5 years distributed among the individual years.

2.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
The annual performance objective for years 2017-2022 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
Annual Objective	
Annual Indicator	80.6
Numerator	12,996
Denominator	16,132
Data Source	HI WIC Services Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	81.0	81.0	82.0	83.0	84.0	85.0

Field Level Notes for Form 10a 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: **Annual Objective**

   Field Note:
   5% improvement over 5 years from baseline

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:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	66.7
Numerator	8
Denominator	12
Data Source	Safe Sleep Hawaii
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	60.0	70.0	80.0	90.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
Objectives were set by Safe Sleep Hawaii considering baseline data and the expected progress over the next 5 years. Safe Sleep Hawaii did a baseline assessment and identified a baseline of 46% in 2015 (6/13=46%)

ESM 6.1 - Development and implementation of Data sharing system for FHSD programs conducting developmental screening, referrals, and services

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	Yes
Numerator	
Denominator	
Data Source	Program Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
The 5-year plan objectives were developed using the baseline 2011-2012 data from the National Survey of Children's Health. Annual objectives were developed projecting a 5% improvement over the next five years.

ESM 7.1 - Percent of children in a home visiting program with an injury-related visit to the emergency department since enrollment.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	1
Data Source	N/A
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.1	0.1	0.1	0.1	0.1	0.1

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: No 2016 data was available.We are in the process of collecting data.	
2.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**
	Field Note: No baseline data available from 2016. Annual objectives are estimated based on federally available data on annual objective from NPM 7. The 2016 FAD estimate was 129.6 per 100,000 (0.13%)	

ESM 7.2 - Number of participants who attend trainings and receive technical assistance on promoting safe, healthy, and respectful relationships.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
No baseline data available so not able to develop 5 year objectives. This is a new measure.

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:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	
Numerator	13
Denominator	51
Data Source	Art and Science Workgroup
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	15.0	21.0	33.0	42.0	48.0	50.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
The preliminary 5-year plan objectives were developed using the National Survey of Child Health data for Hawaii as a baseline and projected an almost 5 percent improvement over the next five years.

ESM 12.1 - The degree to which the Title V Children and Youth with Special Health Needs Section (CYSHNS) promotes and/or facilitates transition to adult health care for YSHCN.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	
Numerator	4
Denominator	33
Data Source	Title V Transition Workgroup
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	17.0	20.0	23.0	25.0	27.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

Column Name: **Annual Objective**

Field Note:
Objectives were set by the Children/Youth with Special Health Needs Section (CYSHNS) staff based on their expected progress, considering the work and program changes that are needed. The CYSHNS staff did a baseline assessment using the Data Collection Form for ESM 12.1 (form can be found in the Supporting Document) and identified a baseline of 4.

ESM 13.1 - The establishment of leadership for the State Oral Health Program under the direction of a dental professional and staff with public health skills.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	State Oral Health Program, Family Health Svcs Div
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
Objectives were set by the Family Health Services team of staff working on oral health. The objectives are based on their expected progress in recruiting, hiring, orienting new oral health program staff. Once the ESM objective is achieved, a new ESM will be developed and submitted.

ESM 13.2 - Completion of teledentistry pilot project at three early childhood settings to reach underserved children and pregnant women.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Virtual Dental Home Planning Team
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

Column Name: **Annual Objective**

Field Note:
Objectives were set by the Department of Health Tele-dentistry project planning committee. The objectives are based on the project work plan which is expected to be completed FFY 2017. Once the ESM objective is achieved, a new ESM will be developed and submitted.

Form 10b
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/Life Course

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 2 - The percentage of Family Health Services Division (FHSD) staff that have increased their knowledge on family/consumer engagement.
Population Domain(s) – Cross-Cutting/Life Course

Measure Status:	Active
Goal:	Increase the engagement of families and consumers in FHSD activities.
Definition:	

Numerator:	Total number of FHSD staff who have expert level (expert level is defined as "I know the topic quite well and am confident talking to families or others about it") knowledge about family/consumer engagement: 11
Denominator:	Total number of staff selected to be part of Title V Planning asked: 46
Unit Type:	Percentage
Unit Number:	100

Healthy People 2020 Objective:	None that are applicable.
Data Sources and Data Issues:	Although the overall goal is to increase family and consumer engagement in FHSD activities, the data is focused on FHSD staff and will be collected and measured annually on staff knowledge of family/consumer engagement. The other strategies and activities will help address the goal but this measure will be used to assist with workforce development and staff knowledge, attitudes, and skills on engaging these stakeholders. By increasing staff knowledge and skills on the subject, it is anticipated that this will, in turn, lead to staff willingness to engage consumers and families in their work. This will, in turn, lead to greater family and consumer engagement in FHSD and Title V activities. In preparation for the annual Title V 2015 meeting, staff were selected by the FHSD Core staff to participate in Title V Strategy meetings and workgroups. These 46 staff were asked to rate their level of knowledge on Family/Consumer engagement according to the following three levels: Expert ("I know the topic quite well and am confident talking to families or others about it"); Intermediate ("I know at least 50% of the topic and I know where I can find more information about it. With help, I am confident I can talk with families or others about it"); Novice ("I am not confident that I know enough about the topic to discuss with others"). This 2015 survey will be used as a baseline in assessing staff knowledge and understanding of the topic. In conjunction with other strategies and activities, this survey will be sent to the same staff to measure the increase of staff knowledge on the subject. Data may be compromised if there are changes to the 46 staff that were surveyed (i.e., staffing changes due to retirement, changing positions, finding other employment, etc.). However, the majority of the staff should continue to be with the FHSD and if there are replacements, then this will be noted in the data charts.
Significance:	Having families and consumers engaged with Title V Programs helps to increase optimal health outcomes for children and families. Benefits include the increased awareness of family needs, increased parent/professional communication, improved policies and responsiveness to family needs, increased availability of families to participate, and

increased responsiveness to federal requirements (Title V Tip Sheet: Lessons Learned from MCH & CSHCN Directors, 2002). Engaging families and consumers at various levels – policy and advocacy, program improvement, and public awareness and promotion – can lead to mutually strengthening and supportive outcomes for Title V programs and for children and families. Other federal programs have also promoted family and community engagement such as the Office of Head Start, U.S. Department of Education, National Parent Teacher Association.

SPM 3 - The percentage of Family Health Services Division (FHSD) staff that have increased their knowledge on Partner Engagement.
Population Domain(s) – Cross-Cutting/Life Course

Measure Status:	Active
Goal:	Increase the meaningful engagement of partners in FHSD activities.
Definition:	

Numerator:	Total number of FHSD staff who have expert level (expert level is defined as "I know the topic quite well and am confident talking to families or others about it") knowledge about partner engagement: 6
Denominator:	Total number of staff selected to be part of Title V Planning asked: 46
Unit Type:	Percentage
Unit Number:	100

Healthy People 2020 Objective:	None that are applicable.
Data Sources and Data Issues:	Athough the overall goal is to increase meaningful partner engagement in FHSD activities, the data is focused on FHSD staff and will be collected and measured annually on staff knowledge of partner engagement. The other strategies and activities will help address the goal but this measure will be used to assist with workforce development and staff knowledge, attitudes, and skills on meaningful engagement of partners. By increasing staff knowledge and skills on the subject, it is anticipated that this will, in turn, lead to staff willingness to engage partners in a meaningful way. This will, in turn, lead to greater partner engagement in FHSD and Title V activities. In preparation for the annual Title V 2015 meeting, staff were selected by the FHSD Core staff to participate in Title V Strategy meetings and workgroups. These 46 staff were asked to rate their level of knowledge on Partner Engagement according to the following three levels: Expert ("I know the topic quite well and am confident talking to families or others about it"); Intermediate ("I know at least 50% of the topic and I know where I can find more information about it. With help, I am confident I can talk with families or others about it"); Novice ("I am not confident that I know enough about the topic to discuss with others"). This 2015 survey will be used as a baseline in assessing staff knowledge and understanding of the topic. In conjunction with other strategies and activities, this survey will be sent to the same staff to measure the increase of staff knowledge on the subject. Data may be compromised if there are changes to the 46 staff that were surveyed (i.e., staffing changes due to retirement, changing positions, finding other employment, etc.). However, the majority of the staff should continue to be with the FHSD and if there are replacements, then this will be noted in the data charts.
Significance:	Because of drastic cuts to the State economy in 2009, Hawaii's Department of Health (DOH) suffered a Reduction In Force (RIF) and a reduction in purchase of service dollars. FHSD had 63.75 permanent positions abolished, which resulted in closure of whole units and programs. FHSD is slowly building its workforce again but many staff had to take on

additional responsibilities and focus on immediate program needs and priorities as opposed to continuing their partnership efforts. While some FHSD Programs may work with partners and stakeholders, Hawaii needs to identify a systems' approach for how this can be done comprehensively, consistently, and effectively. Not all programs may see themselves as working with partners and may not see the value in exerting efforts to improve relationships that they may not think exist. Title V stresses the importance of partner engagement but leaves it to States to decide how to best achieve this. Hawaii recognizes its role in public health to work with partners collaboratively for optimal health and development of children, families, and communities.

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: Hawaii

No State Outcome Measures were created by the State.

Form 10c
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 with a past year preventive medical visit

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 and 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 – Percent of infants placed to sleep on their backs

Measure Status:	Active
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 6.1 - Development and implementation of Data sharing system for FHSD programs conducting developmental screening, referrals, and services
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Active
Goal:	Increase the number of children receiving developmental screening, being referred and receiving services among Hawaii Title V direct service programs.
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	National Survey of Children's Health compiles data for developmental screening. However, Hawaii is looking at data specific to the number of children receiving screening and services. Hawaii's Med-QUEST Division collects information on the Federal Form CMS-416 which is the annual EPSDT Participation Report Form. This is a national form and is used in Centers for Medicare and Medicaid Services and provides statewide data based on claims submitted. However, data is only available on children participating in the Med-QUEST Program, which is approximately 40% of the Hawaii population. While this is significant, this does not provide information on children who have private insurance thus Hawaii does not have a data source for all the children in Hawaii who have received developmental screening in a health care setting. Also, there are other programs and community agencies conducting developmental screening such as home visitors, early childhood programs, and other community agencies. This data is not being systemically reported nor collected. Family Health Services Division, the Title V agency, will create a data system to track developmental screening activities for its programs that provide direct/enabling services. The FHSD team established to work on this Title V priority will determine scoring for this measure.
Significance:	Hawaii is using the ESM to develop a data sharing system within FHSD to collect the number of screenings, referrals, and services provided to children (ages birth-5) in the MIECHV Home Visiting Programs, the CSHNB Hi'ilei Program, and the Early Intervention Section which is the IDEA Part C agency. Once the data sharing system is developed, then Hawaii can actually see the "real" number of children being screened and tracked through referral into services. For Quality Improvement (QI), this data sharing will help pinpoint where increases in screenings, referrals, and follow up are needed. It may also show a need to reduce duplication or monitor where screenings are occurring but referrals are not. Once the system is in place, the ESM will be adjusted to address the needs as identified by the data. Yes refers to whether the data sharing system has been developed and implemented. No refers to the incompletion of the establishment of a data sharing system. Hawaii's Developmental Screening and Services Workgroup has already identified the programs that will be a part of the data system. The next step to establishing the system is to ensure there are formal agreements between the programs, ensure parent consent and confidentiality will be secured, identifying the data elements that will be collected, developing

the communications protocol and meeting frequency to discuss the findings of the data, and the development of a tracking form to monitor the data and progress.

Once the data sharing system is established, then Hawaii will be able to establish a baseline and use the data to improve linkages between the programs to better capture whether the children who are screened and identified with a risk is receiving the services to support their optimal development.

ESM 7.1 - Percent of children in a home visiting program with an injury-related visit to the emergency department since enrollment.
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Measure Status:	Active
Goal:	Reduce the percent of enrolled children in home visiting with a nonfatal injury-related visits to the emergency department to 1% by 2021.
Definition:	**Numerator:** Number of parent-reported nonfatal injury-related visits to the emergency department among index children enrolled in home visiting services. **Denominator:** Number of index children enrolled in a home visiting program **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Home visiting contracted providers collect data on their enrolled children/families, then report to the Department of Health in accordance with HRSA/MCHB funded Maternal Infant Early Childhood Home Visiting (MIECHV) Program Guidelines. The children tracked by this measure represent “index” children who enter MIECHV prenatally or at-birth, but not older siblings or subsequent siblings.
Significance:	During 2013, approximately 679,000 children were confirmed to be victims of maltreatment. The overall national child victim rate was 9.1 child victims per 1,000 children in the population. (US DHHS/ACF Child Welfare Outcomes Report, 2010-2013) Home visiting programs prevent child abuse and neglect, as well as improves maternal and child health, encourages positive parenting, and promotes child development and school readiness. Over time, families and home visitors build partnerships and work together to prevent child injuries, child abuse, neglect, or maltreatment, and reduce emergency department visits.

ESM 7.2 - Number of participants who attend trainings and receive technical assistance on promoting safe, healthy, and respectful relationships.
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Measure Status:	Active
Goal:	To reduce the rate of Child Abuse and Neglect by addressing the impact of children exposed to violence, as well as by promoting safe, healthy, and respectful relationships.
Definition:	**Numerator:** Number of participants who attend trainings and receive technical assistance on promoting safe, healthy, and respectful relationships. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	The Family Support and Violence Prevention Section, Maternal & Child Health Branch
Significance:	A child experiencing or witnessing violence can lead to lasting physical, mental, and emotional harm, e.g., increased attachment problems, regressive behavior, anxiety, depression, aggression, and conduct problems. Other health-related problems (drug abuse and suicide), as well as academic and cognitive problems, delinquency, and involvement in the child welfare and juvenile justice systems are also associated with experiences of violence. These adverse childhood experiences (ACEs) can negatively impact one's health and the ability to foster and sustain safe, healthy, and respectful relationships over a lifetime. Moreover, if these traumatic experiences are not addressed, the effects can be passed from one generation to the next. Many programs and agencies working to both prevent and address the impacts of violence are largely unfamiliar with the ACE research and findings. This information can help improve understanding and inform service delivery. Trainings and technical assistance will also focus on other critical areas of violence prevention including the interconnection of multiple forms of violence, and promoting safe, healthy, and respectful relationships to build the capacity of statewide violence prevention service providers.

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.

Measure Status:	Active
Goal:	Increase resources, training and practice improvement support for adolescent health providers to provide well-care visits aligned to Bright Futures.
Definition:	**Numerator:** Numerator: Total Actual Score from Adolescent Health Data Collection Form **Denominator:** Denominator: Total Possible Score from Adolescent Health Data Collection Form **Unit Type:** Scale **Unit Number:** 51
Data Sources and Data Issues:	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.
Significance:	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.
• 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 12.1 - The degree to which the Title V Children and Youth with Special Health Needs Section (CYSHNS) promotes and/or facilitates transition to adult health care for YSHCN.
NPM 12 – Percent of adolescents with and without special health care needs 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 13.1 - The establishment of leadership for the State Oral Health Program under the direction of a dental professional and staff with public health skills.
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Develop a state oral health program to improve the health of Hawaii families.
Definition:	**Numerator:** n/a **Denominator:** n/a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	The Data Collection Form lists 6 strategies: 1. Recruit for Dental Director 2. Formal interview of candidates for Dental Director 3. Hire and orient Dental Director 4. Recruit for Program Specialist 5. Formal interview of candidates for Program Specialist 6. Hire and orient Program Specialist The measure will be answer “Yes” when all six steps are completed. No data issues are anticipated.
Significance:	For children and pregnant women, 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 41% of pregnant women in Hawaii reported seeing a dentist during their pregnancy. This disparity in dental access and utilization highlights the importance of looking at measures to improve the oral health of families throughout the state. To make a measurable difference in the oral health of all Hawaii’s residents the State Health department is rebuilding the oral health program which was eliminated in 2009. Key to this effort is assuring the program has qualified leadership - a dental professional and staff with public health experience to rebuild critical public health infrastructure. The tasks include: • Establish state oral health leadership and staffing; • Develop an oral health data surveillance system; • Promote evidence based preventive strategies to reduce oral health disease and eliminate disparities; • Set a common agenda among stakeholders by developing a state strategic plan with mutual objectives and common priorities; • Support coalition building and strategic partnerships; • Assess facilitators and barriers to advancing oral health; • Implement communication activities to promote oral disease prevention. Significant barriers have made establishing the positions and hiring challenging.

ESM 13.2 - Completion of teledentistry pilot project at three early childhood settings to reach underserved children and pregnant women.
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Demonstrate the feasibility and effectiveness of teledentistry to improve the oral health of children and pregnant women.
Definition:	**Numerator:** n/a **Denominator:** n/a **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."

Form 11
Other State Data

State: Hawaii

The Form 11 data are available for review via the link below.

Form 11 Data

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

Abbreviated State Action Plan Table

State: Hawaii

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Promote reproductive life planning	NPM 1 - Well-Woman Visit	ESM 1.1	

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce the rate of infant mortality	NPM 4 - Breastfeeding	ESM 4.1	
Reduce the rate of infant mortality	NPM 5 - Safe Sleep	ESM 5.1	

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Improve the percentage of children screened early and continuously age 0-5 years for developmental delay	NPM 6 - Developmental Screening	ESM 6.1	
Reduce the rate of child abuse and neglect with special attention on ages 0-5 years.	NPM 7 - Injury Hospitalization	ESM 7.1 ESM 7.2	

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Improve the healthy development, health, safety, and well-being of adolescents	NPM 10 - Adolescent Well-Visit	ESM 10.1	

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
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 12 - Transition	ESM 12.1	

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Improve the oral health of children and pregnant women.	NPM 13 - Preventive Dental Visit	ESM 13.1 ESM 13.2	
Improve access to services through telehealth			SPM 1
Improve family and consumer engagement in Title V Programs.			SPM 2
Improve partner engagement in Family Health Services Division (FHSD).			SPM 3