

**Maternal and Child
Health Services Title V
Block Grant**

Hawaii

**FY 2019 Application/
FY 2017 Annual Report**

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I. General Requirements

I.A. Letter of Transmittal

DAVID Y. IGE
GOVERNOR OF HAWAII



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DIRECTOR OF HEALTH

STATE OF HAWAII
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In reply, please refer to:
File:

July 13, 2017

Laura Kavanagh, M.P.P.
Acting Associate Administrator
Maternal and Child Health Bureau
Health Resources and Services Administration
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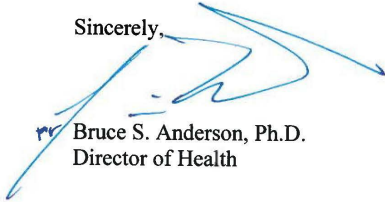
Dear Ms. Kavanagh:

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) 2019 (October 1, 2018 – September 30, 2019). The FY 2019 application and FY 2017 annual report is submitted via the Health Resources and Services Administration Electronic Handbooks (EHBs).

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

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

Sincerely,



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

I.B. Face Sheet

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

I.C. Assurances and Certifications

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

I.D. Table of Contents

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

II. Logic Model

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

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Hawaii is the only island state in the U.S. comprised of 7 populated islands organized into 4 major counties: Hawaii, Maui, Honolulu (Oahu), and Kauai. Spanning nearly 11,000 square miles (with a land mass of 6,422 square miles), the state is home to 1.4 million residents with 80% living in Honolulu, the most populous county.



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

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

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

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

Hawaii Title V MCH Priorities

The 2018 Hawaii State Title V Plan includes eight national priorities based on the 2015 needs assessment. The priorities address the five population domains served by FHSD, as well as the cross-cutting systems building domain. The domains and priorities are described in the table below.



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

Title V National & State Performance Measures (2018)

The new 2018 Title V grant guidance created greater flexibility for states in the selection of priorities, and national and state performance measures. The current Hawaii national performance measures (NPMs) are:

- NPM 1: Well-woman visit
- NPM 4: Breastfeeding
- NPM 5: Safe sleep
- NPM 6: Developmental screening
- NPM 10: Adolescent well visits
- NPM 12: Transition to adult care
- NPM 13.1: Children's oral health

The current Hawaii state performance measures (SPMs) are:

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

The key accomplishments for FFY 2017 and plans for FFY 2018 are summarized below.

DOMAIN: WOMEN/MATERNAL HEALTH

Reproductive life planning

Accomplishments: The Hawaii Maternal and Infant Health Collaborative (HMIHC), of which FHSD is a central participant, continues to promote the use of the One Key Question® (OKQ) screening approach and Long Acting Reversible Contraception (LARC), both evidence-based/informed strategies adopted from the MCH Bureau Infant Mortality CoIN. One outcome of the Collaborative's efforts was a provider memorandum issued by the state Medicaid program, supporting OKQ and Contraception Use. This was a significant event, as the memo provided information on integrating OKQ into provider practice; unbundled LARC reimbursement from delivery service fees; supported stocking of LARC devices in birthing hospital pharmacies, eliminated the need for prior authorization for formulary contraceptive procedures, methods or devices; and allowed reimbursement for a 12-month supply of oral contraceptives.

Challenges: Acquiring timely data to monitor project benchmarks and complete evaluation. Private insurance barriers remain for LARC insertion.

Plans: Continue OKQ training targeting primary care providers. Evaluation of OKQ screening at pilot sites and LARC reimbursements resulting from Medicaid policy change. OKQ pilot sites include Title V WIC services, the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), and Title X Family Planning providers. HMIHC will also focus on public awareness and messaging to promote healthy behaviors including preventive women's health visits and reproductive life planning.

DOMAIN: PERINATAL/INFANT HEALTH

Promoting breastfeeding

Accomplishments: The HMIHC completed a comprehensive breastfeeding promotion plan for the state. A new work group was formed to lead implementation. The Women, Infants and Children (WIC) Services Branch staff serve as co-convenor for this work group. WIC continues its successful Breastfeeding Peer Counselor Project which conducts monthly group sessions and personal support to pregnant and breastfeeding WIC moms.

Challenges: WIC breastfeeding coordinator position eliminated due to Reduction-in-Force action and duties were redistributed to other staff. Birthing facilities improving in appropriate use of breastfeeding supplements; however work continues to improve breastfeeding policies, hospital discharge planning support, and assess staff competency.

Plans: Implementation of breastfeeding state plan in four key areas: leadership, messaging and training, laws and policies, and targeted supports for mothers and families.

Promoting safe sleep practices

Accomplishments: Title V staff and partners reviewed safe sleep policies at 92% of all birthing hospitals in the state. Findings from this process helped to identify workforce training needs and resources, as well as inform the current development of messaging targeted for parents and families. Partnership continues with state Department of Human (DHS), which administers state entitlement programs, to implement a new policy requiring all licensed childcare providers to undergo mandated safe sleep training. The state Child Death Review (CDR) program was also recently reinstated. The CDR is an important source of information on the extent and circumstances of sleep-related deaths, as well as prevention recommendations.

Challenges: The practice of co-sleeping among local families may be related to ethnic/cultural norms, and also small or multi-family living arrangements due to high housing costs. These factors must be considered when providing safe sleep education that engages parents and other care givers in making informed decisions on creating a safe environment.

Plans: Complete review of all birthing hospital policies and training needs. Continue partnership with DHS to educate caregivers, collect family input on messaging, and explore prevention programs to reach high risk families served by DHS entitlement programs. Use CDR findings and recommendations to inform program planning and policy development. Evaluate effectiveness of Pack n' Play crib distribution programs.

DOMAIN: CHILD HEALTH

Improve screening early and continuously for developmental delay

Accomplishments: Guidelines on developmental screening, referral, and services were completed with stakeholder input and disseminated to the state early childhood (EC) community. Continued partnership with state EC organizations to promote system of developmental screening and referral. FHSD's Early Childhood Comprehensive Systems grant contracted with community providers to increase developmental screening rates of 3-year-olds. An FHSD data sharing system for EC programs was established, and data were analyzed to monitor and improve screening and referral activity among programs.

Challenges: Need remains for an integrated developmental screening system to ensure there are available supports statewide and in each community. This includes need for infrastructure support, including training and data systems (e.g., lack of detail within early and periodic screening, diagnosis, and treatment [EPSDT] Medicaid data).

Plans: Hire staffing for ECCS grant implementation on Maui. Work with families and parent engagement organizations to develop family-friendly materials on the importance of screening.

Improve the oral health of children

Accomplishments: The State Oral Health Program (SOHP) is now fully staffed and operating under the direction of a dental professional and personnel with public health skills and experience. Head Start/Early Head Start oral health screening was planned and implementation has begun. A statewide strategic planning process for oral health has started, and the State Oral Health Coalition was revived. The second year of a 3-year Virtual Dental Home teledentistry pilot project at early childhood settings (WIC, Head Start, preschool) was completed.

Challenges: Maintain adequate/sustainable funding for SOHP.

Plans: Publish findings and recommendations from Head Start/Early Head Start screening survey; complete state strategic oral health plan, complete third year of Virtual Dental Home teledentistry project; support coalition-building/partnerships to assure broad participation in state oral health planning. Await award announcement of Centers for Disease Control & Prevention 5-year oral health grant to develop state dental sealant program, community water fluoridation, and support integration of oral health into chronic disease prevention program.

Reduce the rate of child abuse and neglect (CAN)

Accomplishments: The FHSD's violence prevention programs collaborated to conduct Adverse Childhood Experiences (ACEs) trainings for multi-disciplinary/agency audiences, focusing on how violence impacts children's brain development and health over the lifespan. MIECHV continues to provide evidence-based services to at-risk families. MIECHV is in discussion with DHS, which administers the state's Child Welfare Services, to explore possible collaboration to implement a Nurse-Family Partnership home visiting model.

Challenges: Strengthening public health knowledge and skills to assure development of population-based approach to CAN including surveillance, assessment, systems building, and planning.

Plans: The Community-Based Child Abuse Prevention (CBCAP) program is developing a CAN surveillance system, and will also conduct system mapping as part of its needs assessment. Participation in the national MCH Workforce Development Center Technical Assistance will be used to assist with planning.

DOMAIN: ADOLESCENT HEALTH

Adolescent health and well-being

Accomplishments: Partnered with Hawaii Maternal Child Health Leadership Education in Neurodevelopmental & Related Disabilities (MCH LEND) and Hilopaa Family to Family Health Information Center (F2FHIC) to conduct lunch time webinars with pediatric specialists on Adolescent Well Visits (AWV). Hilopaa also conducted trainings on adolescent Screening, Brief Intervention, and Referral to Treatment (SBIRT) for pediatric providers. Title V staff and partners also began development of Adolescent Resource Toolkit (ART), aiming to deliver information about well visits and overall healthy behaviors directly to adolescents.

Challenges: Need for diversification of partnerships to conduct provider trainings and implement activities.

Plans: Continue training and technical assistance for adolescent health providers that provide well-care visits, so they are more teen-centered and aligned to *Bright Futures* practices. Secure further input from adolescents on the draft ART and assist with online resource development.

DOMAIN: CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

Transitions to adult health care

Accomplishments: The 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, with the ultimate goal of incorporating transition planning into CYSHNS service coordination for all CYSHNS-enrolled youths and their families. A transition policy and protocols were developed with family input and implemented by CYSHNS. The CYSHNS data system is being upgraded to permit tracking and monitoring of transition planning for clients. Education and public awareness efforts continued through transition fairs, conferences, and other events, in collaboration with other state and community partners.

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

Plans: Evaluate the transition protocols implemented in CYSHNS service coordination. Continue development of the data monitoring system. Continue to support education and public awareness on transition to adult health care at fairs, conferences, and other events, in collaboration with partners.

DOMAIN: CROSS-CUTTING/SYSTEMS BUILDING

Promote telehealth

Accomplishments: FHSD is implementing or increasing telehealth activities, including for workforce training, as well as for direct services to the community (e.g., genetics, newborn screening, early intervention, WIC services and MIECHNV activities). Project ECHO Hawaii, of which FHSD is a key partner, continues to use videoconferencing to build primary care workforce capacity while improving patient access to specialty health care in rural communities. FHSD is supporting a pilot teledentistry program on Hawaii island. FHSD staff are using videoconferencing daily to maintain and improve communication among DOH programs and community partners.

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

Plans:

Telehealth infrastructure development – continue working with community partners to develop and implement policies/procedures for telehealth and develop a network of telehealth sites and personnel.

Workforce development – continue using training curriculum to train FHSD staff on telehealth.

Service provision – continue to identify services that may be provided using telehealth, pilot innovative programs, and expand successful pilot programs.

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

MCH Workforce Development

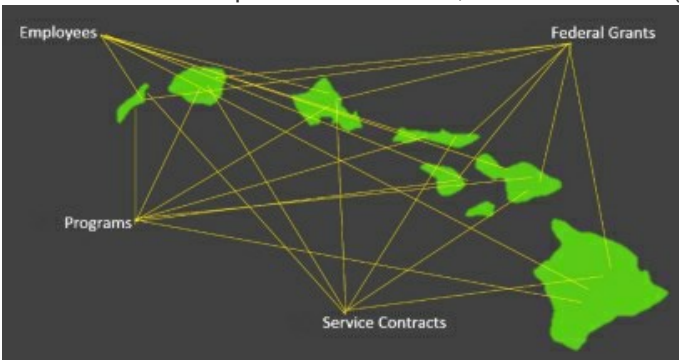
With 277 FTE, FHSD staff have diverse training backgrounds and program experience in varied fields and subject areas. Many have topic-specific knowledge and program management expertise, but they may not have foundational public health skills needed to assess and align community data, system resources, and prevention strategies to improve Title V national performance measures. Therefore, FHSD utilizes technical assistance and the process of developing the Title V report/application to help build staff public health capacity. Other workforce efforts are described in the report.

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



FHSD provides all levels of service delivery: direct, enabling, and infrastructure building. One of the largest Divisions in DOH, FHSD is comprised 3 branches – Maternal and Child Health (MCH), Children with Special Health Needs (CSHN), and Women, Infants and Children (WIC) Services. Together the Division administers 30 programs, 22 federal grants, approximately 150 service contracts with community-based organizations totaling roughly \$50M, all with 277 FTE positions statewide.

In 2017 the FHSD budget was \$103.5 M. Nearly \$2.2 M was provided by Title V, with \$45.9 M state matching funds, and an additional \$55.4 M in other federal funds. Of the state’s overall population, FHSD programs reached an estimated 48% of pregnant women, 100% of all infants, 12% of children 1-21 years of age, 17% of children with special health needs, and 4% of others (general adult population).



To support the infrastructure needed to administer MCH programs statewide, Title V funds are used for key staff positions (18.1 FTE) including epidemiologists, research statisticians, MCH and CSHN program managers, a part-time Pediatric Medical director, nurses, a nutritionist, an audiologist, and contract manager. These positions are critical to: 1) securing, leveraging, and managing a broad array of funding sources; 2) addressing statewide surveillance needs; 3) developing critical statewide

partnerships; and 4) improving quality to assure services are family-centered, culturally relevant, and community based.

III.A.3. MCH Success Story



Hawaii Title V works closely the Hilopa’a Family to Family Information Center (HF2FIC) to engage families and youth to improve services. A family’s journey may involve participation in many Title V programs; allowing families to see MCH services from a life course perspective.

Title V was delighted to sponsor two families (two mothers and their daughters) to attend the national 2018 AMCHP conference to help expand their MCH education and were surprised the families emerged as natural advocates and educators for Title V resources. Both families have utilized CSHN services since the girls were newborns. Now young adults, both daughters are determined to give back. HF2FIC has supported both families to share their life experiences to provide valuable feedback to Title

V programs over the past two years.



In D.C. they shared their stories with the Hawaii Congressional delegation and took to social media to share their support for Title V. Moving beyond her role as advisor, Victoria, age 22 (above) was a panel presenter on transition to adulthood at a recent statewide conference for CSHCN families. She sees herself as an advocate now, "I can do a lot to change the world".

Alohi, age 19 (left), has overcome her special needs and is attending community college to become a nurse. Her experiences drive her to be of service to others and her community. She has a special appreciation for MCH populations, and sees herself playing a pivotal role to help others.

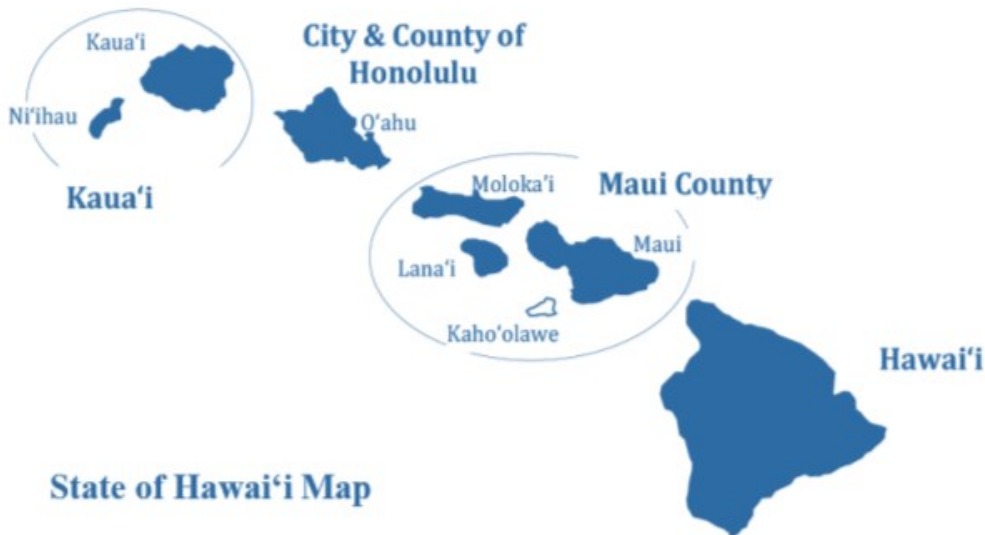


III.B. Overview of the State

GEOGRAPHY

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

population size and 4th smallest by land area.



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

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

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

Geographic access is further limited because public transportation is inadequate in many areas of the state except

for the Honolulu metropolitan area. Over the past five years, the islands of Maui, Kauai, and Hawaii have established limited public bus service, but their use by residents is largely sporadic. Residents in rural communities, especially on the neighbor islands, rely on automobiles to travel to major population centers on their island where health care services are available including primary care, hospital, specialty, and subspecialty services. Because of the mountainous nature of the islands, road networks are sparse and, in some places, limited to a single highway near the coast. Access to emergency care on neighbor islands often requires the use of helicopters or fixed-wing aircraft.

DEMOGRAPHICS

The estimated 2016 state population is 1,428,557 residents, the 30 most populous state in the U.S. Oahu (992,605 residents) is home of 69.5% of the state's population, while 13.9% live on the Big Island (198,449 residents), 11.6% (165,379 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% in the county of Kauai, 6.8% in the county of Maui, 7.2% in the county of Hawaii, and 4.1% in the city and county of Honolulu.

ETHNIC DIVERSITY

Hawaii is one of the most ethnically diverse states in the U.S. with no single race majority. According to the 2016 American Community Survey (ACS), 24.0% of the population reported two or more races, and the following single race proportions (White=25.0%, Asian=38.0%, Native Hawaiian or Other Pacific Islander (NHOPI)=10.1%, Black=2.0%, and American Indian/Alaskan Native=0.2%). The largest Asian single race sub-groups were Filipino (15.3%), and Japanese (12.4%) and the largest NHOPI single race sub-group was Native Hawaiian (6.1%). The individual Asian and NHOPI sub groups are listed in the table below and show the heterogeneity of these aggregated Race groupings.

Race Group		Detailed Sub Groups	
Asian		Filipino Japanese Chinese Korean Vietnamese Asian Indian Thai Laotian Taiwanese Cambodian Indonesian	
Native Hawaiian or Other Pacific Islander	Polynesian	Native Hawaiian Samoan Tongan Tokelauan Tahitian	
	Micronesian	Guamanian or Chamorro Marshallese Kosraean Chuukese Palauan Yapese Saipanese I-Kiribati	
	Melanesian	Fijian Papua New Guinean Ni-Vanuatu Solomon Islander	
	Sources: US Census Bureau. The Asian Population: 2010. 2010 Census Briefs. Issued March 2012; C2010BR-11.		
	US Census Bureau. The Native Hawaiian and Other Pacific Islander Population: 2010. 2010 Census Briefs. Issued May 2012; C2010BR-12.		

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

	Resident Population in the State of Hawaii (N)	Percent of State Population (%)	Proportion Reporting at least one other Race (%)
White Alone	357,994	25.0%	0
White Alone or in Combination	613,488	42.9%	41.7%
Native Hawaiian or Other Pacific Islander (NHOPI) Alone	144,568	10.1%	0
NHOPI Alone or in Combination	371,680	26.0%	61.1%
<i>Native Hawaiian Alone</i>	86,503	6.1%	0
<i>Native Hawaiian Alone or in Combination</i>	302,926	21.2%	71.4%
Asian Alone	543,448	38.0%	0
Asian Alone or in Combination	810,627	56.7%	32.9%
<i>Filipino Alone</i>	217,937	15.3%	0
<i>Filipino Alone or in Combination</i>	377,904	26.4%	42.3%
<i>Japanese Alone</i>	177,487	12.4%	0
<i>Japanese Alone or in Combination</i>	313,014	21.9%	43.2%
<i>Chinese Alone</i>	52,266	3.7%	0
<i>Chinese Alone or in Combination</i>	203,022	14.2%	74.3%

Source: U.S. Census Bureau. 2016 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, 2016 American Community Survey

Those that report two or more race groups are not included in the single race groups commonly reported. Due to the large proportion with more than one race, recommendations are to report race as "alone" or "alone or in combination" with another group. For example, Native Hawaiian accounted for 21.2% of the state population when reported as "alone or in combination," compared to just 6.1% when Native Hawaiian is reported singly. There is also variation among race sub groups an overall estimate of 32.9% of those in the Asian Alone or in combination reporting another race but variation in the 3 largest sub groups range from 42.3% in Filipino to 61.2% in Chinese. The other Asian sub groups are likely newer immigrants to Hawaii compared to these three and have smaller numbers reporting more than one race group.

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

Immigration

Hawaii is considered a gateway to the U.S. for immigrants from Asia and the Pacific. According to the 2016 ACS, 18.3% of Hawaii's population is foreign-born, the 6th highest percentage in the U.S. Nearly 39,000 immigrants were legally admitted to the state between 2003 and 2013, mainly from the Philippines, Japan, Korea and Vietnam. Smaller groups of Hispanic immigrants have settled in parts of Maui and Hawaii Islands, attracted by jobs in tourism and agriculture. Estimates of illegal immigrants in Hawaii range from six to nine thousand.

Languages Spoken

Because of Hawaii's ethnic diversity, limited English proficiency poses challenges for educational achievement, employment, and accessing services, and may impact the quality of care for immigrant communities. Based on 2012-2016 ACS, an estimated 25.7% Hawaii resident ages 5 years and over spoke a language other than English at home, compared to 21.1% nationally. An estimated 12.6% of Hawaii residents reported limited English proficiency (4th highest state ranking), compared to 8.5% nationally. The most common languages spoken at home other than English include Other Pacific Island languages (81,555), Tagalog (58,345), Japanese (45,633), and Spanish (25,490), followed by Chinese (17,360), Korean (17,276) and Vietnamese (9,418).

In School Year 2015-2016, 8.3% (13,619) 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 removed their eligibility to these entitlement programs with the state assuming most of the costs for services.

There are reports of high rates of morbidity due to chronic disease (diabetes, obesity, smoking), reports of communicable diseases (tuberculosis, Hansen's disease/leprosy), and other medical concerns (which may be related to U.S. nuclear tests conducted in the Pacific nations) with additional challenges due to substantial language and cultural barriers within the COFA population. In 2016, the social, health, educational, and welfare system costs attributed to the estimated 14,700 COFA migrants in Hawaii was \$142.3 million dollars. Estimates indicate roughly 1,000 migrants are homeless. Migrants account for about 2-3% (400-600) births annually in Hawaii, with low rates of prenatal care utilization, high rates of low birth weight, and recent concerns about high rates of NICU admissions^[2].

In 2015, the Title V agency served an estimated 8,858 COFA migrants at a cost of \$5.4M. 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 2016,

comprise an estimated 7.8% of the state's population (112,075 people^[3]). 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 2017 Point-in-Time homeless study estimates the total number of homeless individuals statewide at 7,220. The proportion of unsheltered individuals (53.0%) was higher than sheltered individuals (47.0%). The trend of homeless has steadily grown over the past 5 years from 6,335 in 2013. About 37.2% (2,685) of the homeless were part of families, including 17.3% (1,250) children under age 18 years living sheltered, and 299 children living unsheltered.

Maternal and Child Population

The 2016 estimates show that there were 267,210 women of reproductive age (15-44 years old) a 1.9% increase from 2010, representing 18.7% of the entire state population.

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

The 2016 population estimates show that there were 178,621 children 9 years of age or younger in Hawaii, which represents a 4.6% increase from 2010. This group represents 12.5% of the state population. There were 160,416 children 10-19 years of age in Hawaii, which represents a 4.2% decrease from 2010. This group represents 11.2% of the state population.

Based on the 2016 National Survey of Children with Special Health Care Needs (CSHCN), there are an estimated 42,109 CSHCN, representing 13.7% of all children ages 0-17 years old.

Older Population

Hawaii's population, like the U.S., is aging. Based on 2016 population estimates, persons age 65 years and over comprised 17.1% of the population, compared to 14.3% in 2010. Nationwide, this population comprised 15.2% in 2016 compared to 13.0% in 2010.

ECONOMY

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

Economic Growth

The Hawaii State Department of Business, Economic Development and Tourism (DBEDT) second quarter 2018 outlook shows accelerated 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-agriculture payroll jobs and healthcare industries^[4]. The state real gross domestic product (GDP) grew 1.7% in 2017, and is expected to grow by 1.9% in 2018 and 1.6% in 2019. The per capita real GDP in Hawaii was \$51,277 in 2016 (in 2009 dollars), \$700 or 1.4% higher than the U.S. average. Hawaii ranked 20th among the 50 states.

Unemployment

Hawaii unemployment rates reflect the state's economic recovery. The state's unemployment rate peaked at 7.4% after the 2009 recession with a record 47,000 individuals unemployed. According to the Bureau of Labor Statistics, the annual average unemployment rate in Hawaii was 2.9% in 2016, 2.0% point lower than the U.S. average of 4.9%^[6]. Hawaii ranked the lowest among the 50 states.

State Budget

According to the Hawaii Department of Taxation, the State Council on Revenues raised its forecast for growth in the State General Fund tax revenue in FY 2018 from 5.3% to 7.3^[6]. The Council also raised its forecast for growth rates from 4.5% to 5.0% in FY 2019. The Council noted that the recent growth trend was due to an increase in individual income taxes and General Fund revenue, resulting from higher personal state 2018 income tax rates on high income earners, continued robust economic activity, and the stimulus effects of the Tax Cuts and Jobs Act passed in December 2017.

Tourism

2017 was another record breaking year for tourism with 9.3 million travelers coming to the islands and visitor expenditures of \$16.8 billion. Although vulnerable to changing markets and trends, in 2018, forecasters expect visitor arrivals and visitor expenditures will continue to increase.

Poverty

Based on 2016 estimates, Hawaii's poverty rate was 9.3% (all ages in poverty), lower than the U.S. rate of 14.0%. This represents an estimated 129,569 individuals living in poverty in the state; over 30,507 or 10.1% of those under 18 years of age live in households below the Federal Poverty Level (FPL). Like unemployment rates, poverty rates are variable across counties: Honolulu 8.5%; Maui 8.3%; Kauai 6.1%; and Hawaii 15.4%.

The official FPL obscures the struggles faced by many families in Hawaii because of the high cost of living in the state and the generally low wage structure given the dependence of service industry jobs in tourism. The Census Supplemental Poverty Measure, which considers factors such as the cost of living and entitlements, reports that the 2016 poverty rate for Hawaii was 14.0%^[7].

Wages

According to the Bureau of Labor Statistics, average annual wages for employees in Hawaii was \$48,178 in 2016, \$5,443 or 10.2% lower than the U.S. average of \$53,621. 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 \$45,546 in 2016, \$7,969 or 14.9% lower than the U.S. average, ranking Hawaii 32th.

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 businessinsider.com, "The Best and Worst States to Make a Living 2016," 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 2018, the median housing cost for a single-family dwelling on Oahu was \$790,000 and for a condominium was \$416,000. The median monthly owner mortgage cost in 2016 was \$2,239, \$753 or 50.7% higher than the U.S. average. Among these homeowners, 28.3% spent 35% or more of their household income, which was higher than the U.S. average of 21.3% (2016 ACS 1-year estimates). Hawaii ranked the highest in the nation for this indicator. Not surprisingly, the homeownership rate in Hawaii in 2016 was one of the lowest in the U.S. (47th among the 50 states) at 57.2%, which was lower than the U.S. average of 63.1%.

Rental Costs

Even for working families, the high cost of fair market rent is out of reach. Based on 2016 ACS 1-year estimates, estimated 47.4% 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 2016 was \$1,483, \$502 or 51.2% higher than the U.S. average of \$981. 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 2016 ACS 1-year estimates, the percentage of multigenerational family households among all family households in Hawaii was 11.5%, which was higher than the U.S. average of 5.9%. Hawaii had the highest rate among the 50 states.

Cost of Health Insurance

Health insurance premiums continue to increase annually and can comprise a significant amount of an individual or family's budget. According to the Hawaii State Insurance Commissioner^[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 Services Infrastructure

According to the Hawaii State Health Planning and Development Agency, a 2016 report lists about 100 health facilities in the state^[9]. These facilities include, but are not limited to, 26 hospitals^[10], 2 psychiatric only hospitals, 38 federally qualified health centers and rural health clinics^[11]. Of the 26 hospitals, 12 are birthing hospitals, and 6 have psychiatric beds. There are three pediatric hospitals with NICUs on Oahu while other hospitals have less acute pediatric services.

There are 440 family and general practitioners, 90 obstetricians and gynecologists, and 130 pediatricians in the State of Hawaii^[12]. Based on the 2016 population estimate (1,428,577), there are 6.3 obstetricians and gynecologists, and 9.1 pediatricians per 100,000 population, which are similar or slightly higher compared to the estimates in the U.S. population while the rate for family and general practitioners in Hawaii (30.8 per 100,000 population) is below the national rate (38.1).

Hawaii has unique geographic needs as demonstrated in maps located in the supporting documents section. Maps show locations of birthing hospitals and community center and clinics.

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 in 2013 to about 360,000 in 2017^[13]. 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 demonstration 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 133% of FPL.

As of March 2018, The Hawaii Medicaid Program provided coverage to 359,559 individuals with 115,784 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 Healthcare.gov. However, the state-funded Medicaid Premium Assistance Program may help, by paying the premiums for eligible COFA migrants and legally permanent residents who have incomes less than 100 percent of the FPL

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

CMS approved the Hawaii State Plan Amendment which eliminated restrictions to telehealth services. 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] Hawaii State Department of Education, English Language Learners, P. 48 of the Consolidated State Performance Report for school year 2015-16 <https://www2.ed.gov/admins/lead/account/consolidated/sy145-156part1/hi.pdf>

[2] COFA reports are found on <https://www.doi.gov/oia/reports/Compact-Impact-Reports> . The latest available update is 2016.

[3] Number of armed forces residents and military dependents at http://dbedt.hawaii.gov/economic/databook/2016-individual/_01/

[4] Report on Hawaii’s economy <http://dbedt.hawaii.gov/economic/qser/>

^[5] 2016 unemployment rate is found at <https://www.bls.gov/lau/lastrk16.htm>

^[6] General fund forecast on May 24, 2018, http://tax.hawaii.gov/useful/a9_1cor/

^[7] Supplemental Poverty Measure is found on <https://www.census.gov/library/publications/2017/demo/p60-261.html>

^[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/>

^[9] Based on the facility address provided on <http://health.hawaii.gov/shpda/agency-resources-and-publications/health-care-utilization-reports-and-survey-instructions/2016-data/>

^[10] Based on information provided on <http://health.hawaii.gov/ohca/medicare-facilities/hospitals/>

^[11] Based on information provided on https://health.hawaii.gov/docd/files/2013/07/VFC_Centers.pdf

^[12] Based on state data provided in Form 11.

^[13] Based on annual report found on <http://humanservices.hawaii.gov/reports/annual-reports/>

III.C. Needs Assessment

FY 2019 Application/FY 2017 Annual Report Update

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

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

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

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

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

Health status and needs of state's MCH population

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

Recent dissemination efforts include:

- Peer-reviewed publication in *Maternal and Child Health Journal* – The relationship of adverse childhood events (ACEs) to smoking, overweight, obesity, and binge drinking among women in Hawaii – more than half

of adult women reported at least one ACE. The paper highlights the relationship between ACEs and impacts in adult life.

- Presentations:
 - Hawaii Maternal and Infant Health Collaborative (HMIHC) – interpregnancy interval.
 - Hawaii PRAMS steering committee – indicators for use in upcoming trend report.
 - AMCHP conference – training providers on One Key Question.
 - Bright Smiles Hawaii workgroup – treatment in emergency departments (EDs) for oral health issues.

Perinatal/Infant Health Domain – There are approximately 23,000 pregnancies and 19,000 births every year in Hawaii. The Title V program focuses on breastfeeding and safe sleep for infants. The rate of exclusive breastfeeding for 6 months continues to improve – 30% in 2014, compared to 18% in 2007.

Infants being placed on their back to sleep also improved – 82% in 2015, compared to 72% in 2007. However, there are still significant disparities, with mothers under 20 years of age (70%), 20-24 years of age (76%), Native Hawaiian (73%), and being on Medicaid/QUEST during prenatal care (76%) having lower estimates.

Recent dissemination efforts include:

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

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

Recent dissemination efforts include:

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

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

Recent dissemination efforts include:

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

Children with Special Health Care Needs (CSHCN) – The population of CSHCN in Hawaii is estimated to be 42,000 which represents 14% of the child population under 18 years of age, and 3% of the larger state population. Hawaii’s Title V program focuses on transition to adult health care for this domain. The numbers available for

detailed analysis are limited at this time, with no differences seen among subgroups.

Program capacity and systems of care

Hawaii's Title V program capacity expanded with new program funding, but is also still adjusting to the loss of 44.5 WIC positions due to reductions-in-force (RIF) as described in last year's report. New program areas include the reinstatement of the Child Death Review program and establishment of a new Maternal Mortality Review through passage of State Act 203 in 2016. The CSHNB received Childhood Lead Poisoning Prevention (CLPP) funding from Centers for Disease Control and Prevention (CDC) to reduce lead exposure and lead poisoning of children from birth through five years of age. The cooperative agreement will strengthen blood lead level testing, surveillance, population-based interventions, and identify lead-exposed children and link to services.

Partnerships and collaborations

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

One of FHSD's most important partners is the Department of Human Services (DHS) which administers federal social service/entitlement programs targeting families. DHS programs include Medicaid, Temporary Assistance for Needy Families, Food Stamps, Child Welfare Services, Childcare subsidies, and Vocational Rehabilitation. DHS has undertaken a 'Government Transformation' process called Ohana Nui (extended family). Employing the Two-Generation best practice

approach, DHS is working to transform service delivery to address the needs of children, parents, and grandparents early and concurrently, resulting in better outcomes for the family. Implementing this new philosophy requires tearing down silos, thinking beyond the limitations of funding streams, and work across divisions, programs, and teams. The process is designed to improve and coordinate service delivery across the department to break the cycle of intergenerational poverty.

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

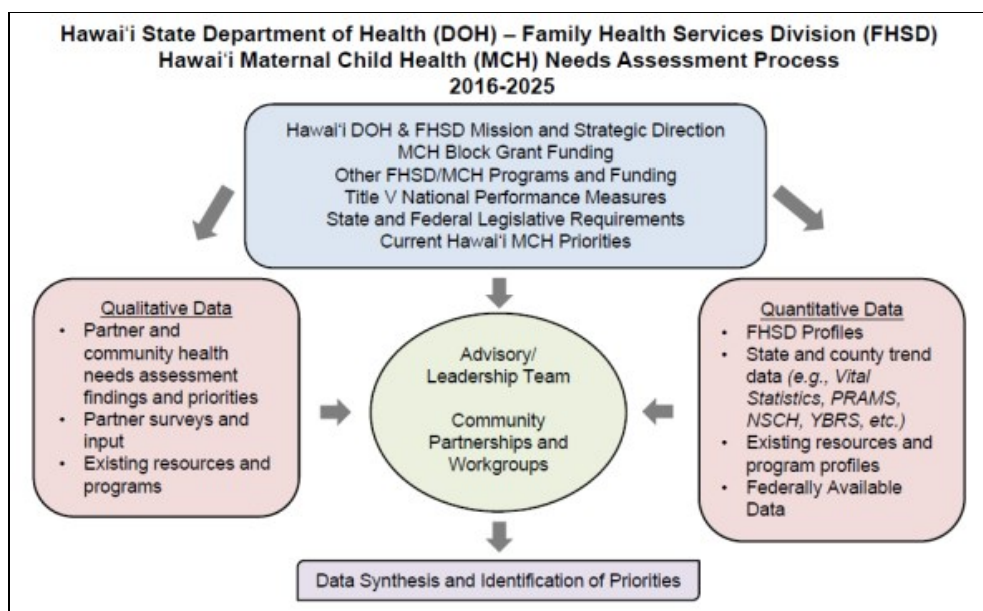
Existing public-private partnerships continue. Highlights include:



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

Needs Assessment Planning

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



Efforts to operationalize needs assessment

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

Logic models were introduced for each of the national performance measures as recommended at 2018 AMCHP skills building sessions. Logic models are widely used tools in public health for both planning and evaluation. The five major parts of a logic model are: resources, activities, short-term outputs, longer-term outcomes, and contextual

conditions (e.g., conditions beyond our control that must be considered such as culture, rurality, health and service gaps, and socioeconomic conditions). Logic models were instituted not only to map out each program's strategies and expected outcomes, but also to guide assessment of alignment and appropriateness among strategies, short-term measures (i.e., evidence-based strategy measures) and longer-term measures (i.e., national performance and outcome measures). Title V staff partnered with Dr. Sugimoto-Matsuda on the assembly and review of each logic model. For a few domains, minor adjustments were identified during this phase of the needs assessment process. Logic models are included and referenced in the State Plan narratives.

Changes in organizational structure and leadership

FHSD now has 277 FTE staff, of which 18.1 FTE are Title V-funded. Also, 46 FTE are located on neighbor islands. After major loss of 44 WIC positions in 2017, the FHSD workforce has remained relatively stable.

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

- Wendy Nihoa serves as the new PRAMS Coordinator, bringing 15 years of public health management and leadership experience to the program.
- FHSD filled to key administrative positions: the Division Administrative Officer, Lane Aakhus, and Division Accountant, Christine Kok.
- Leadership and staffing positions for the State Oral Health Program positions have been filled. FHSD also submitted a new CDC oral health funding application and is waiting award announcements for the competitive 5-year grants.
- Recruitment continued for an Epidemiologist II for the Division Surveillance, Evaluation, and Epidemiology Unit. The position was filled in 2018 and is temporarily funded using the CDC Preventive Health and Health Services Block Grant administered by the DOH Planning Office. Permanent funding will be sought.
- CSHNB filled the newly established Early Childhood Program Specialist position in the Children and Youth with Special Health Needs Section. This position will address early childhood issues, including developmental screening, with a focus on children with special health care needs.

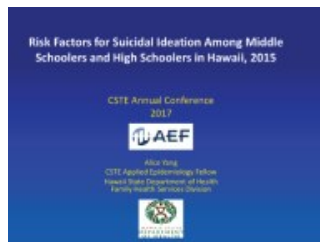
II.B.1. PROCESS

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.



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

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

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

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

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

II.B.2. FINDINGS

II.B.2.a. MCH POPULATION NEEDS

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

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

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

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

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

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

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

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

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

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

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

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

Partnership with other DOH agencies:

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

Partnership with other state agencies

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

- Family receiving SNAP, TANF, TANOF are adjunctively income-eligible for WIC. All WIC enrolled families receive a DHS brochure on benefits.
- WIC and DHS collaborate to ensure timely services to homeless pregnant and postpartum moms and families with young children. DHS can directly refer clients to WIC clinic operations staff to expedite enrollment.
- The FHSD Early Childhood Coordinator is working with DHS-Child Care program to increase supports for providers working with infants and toddlers. The development of an infant-toddler specialist mental health/behavioral network is being explored.
- Early Intervention Services and the Children Welfare Services (CWS) are collaborating to identify children under age 3 who may qualify for EI services under Part C of IDEA, who are involved in substantiated cases of child abuse or neglect; and creating a seamless system of referral and services for families served by both CWS and EIS. A Memorandum of Agreement is being updated.
- Children and Youth with Special Health Needs Section (CYSHNS) presented its transition efforts at a DHS EPSDT meeting on Current Supports for Children Transitioning to Adulthood.

Public-private partnerships

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

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

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

From 2016-2017, 150 CDR reviews were completed. The MMR will hold its first review on July 31, 2017. A

permanent full-time registered nurse position was established to serve as the CDR/MMR coordinator.

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

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

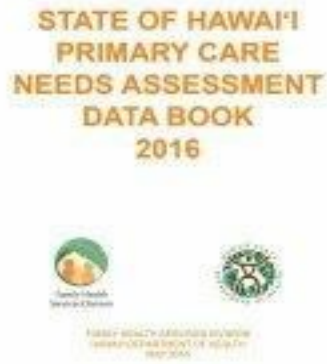
2017 Legislation

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

FY 2017 Application/FY 2015 Annual Report Update

II.B.1. PROCESS

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



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

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

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

Special studies – See Oral health/Hawaii Smiles below.

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

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

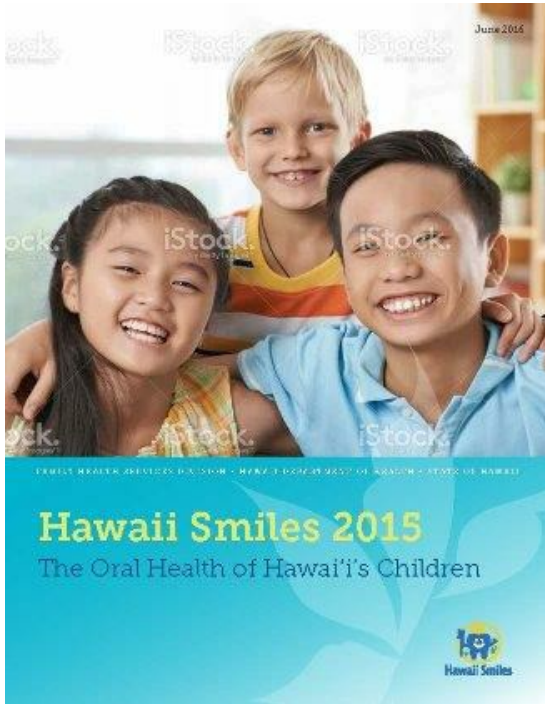
and longitudinal data linkages, perinatal substance use, and infant/toddlers.

Community Health Needs Assessments (CHNA):

The FHSD Office of Primary Care and Rural Health (OPCRH) continues in 2016 its facilitation of CHNA at a rural critical access hospital (CAH) on Oahu. The assessment process takes several months from initial data collection, survey development, compilation of findings, strategy prioritization, and completion/public dissemination of a final hospital report. CHNAs represent the start of community conversations and collaborations, and often inform other health assessments and strategic plans in Hawaii. OPCRH is also developing brief community health profiles for each CAH or rural community as requested.

II.B.2. FINDINGS

II.B.2.a. MCH POPULATION NEEDS



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

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

Zika virus infection: In January 2016, DOH received laboratory confirmation of congenital Zika virus infection in a microcephalic infant born in Hawaii to a mother who emigrated from Brazil early in her pregnancy. For the period 2015-2016, as of 6/29/16, Hawaii had 10 travel-related cases who were infected outside of Hawaii. No cases were acquired locally. While Zika virus is not endemic in Hawaii, it is transmitted by *Aedes* species mosquitoes which can be found throughout Hawaii. A concern is that Zika cases among travelers visiting or returning to Hawaii may result in the Zika virus becoming endemic and spreading locally. Needs

in Hawaii related to MCH include: monitoring Zika-infected pregnant women through pregnancy and their infants through the first year of life, information sharing, disseminating DOH materials to families/community, etc. See Emerging Issues for more information about Zika.

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

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

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

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

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

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

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

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

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

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

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

Partnership with other DOH agencies:

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

Partnership with other state agencies:

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

Public-private partnerships:

- No Wrong Doors: CSHNB is participating in the No Wrong Doors statewide initiative to improve access to long-term services and supports for individuals with disabilities and chronic conditions. This is an initiative of the Governor's Office of Healthcare Transformation, with funding from the Administration for Community Living. Participants include the Executive Office of Aging, DOH Adult Mental Health Division, DOH Developmental Disabilities Division, DHS Med-QUEST Division, and DHS Division of Vocational Rehabilitation, and other agencies.
- Hawaii Maternal and Infant Health Collaborative (HMIHC) is a major partner for FHSD. Established in 2014, it is a public-private partnership to improve birth outcomes and reduce infant mortality. Diverse partners include academia, professional organizations, major health insurers, Hospital Association 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:

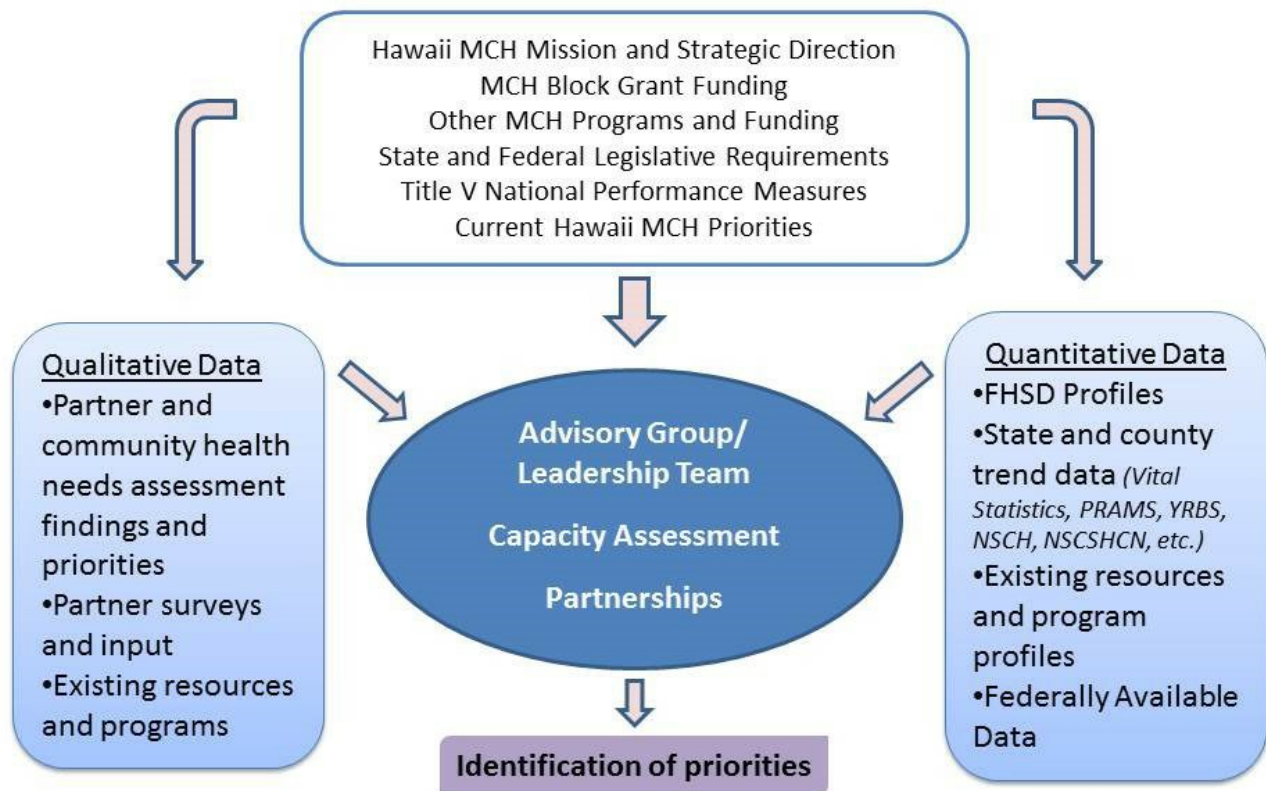
- Life course approach: Experiences or exposures during critical periods of an individual's life (e.g., infancy, childhood, adolescence, and childbearing age) can have long-term implications.

- 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.

Hawaii Maternal Child Health Needs Assessment Process 2016-2020



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, Hiloopaa 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% in 2012) 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).

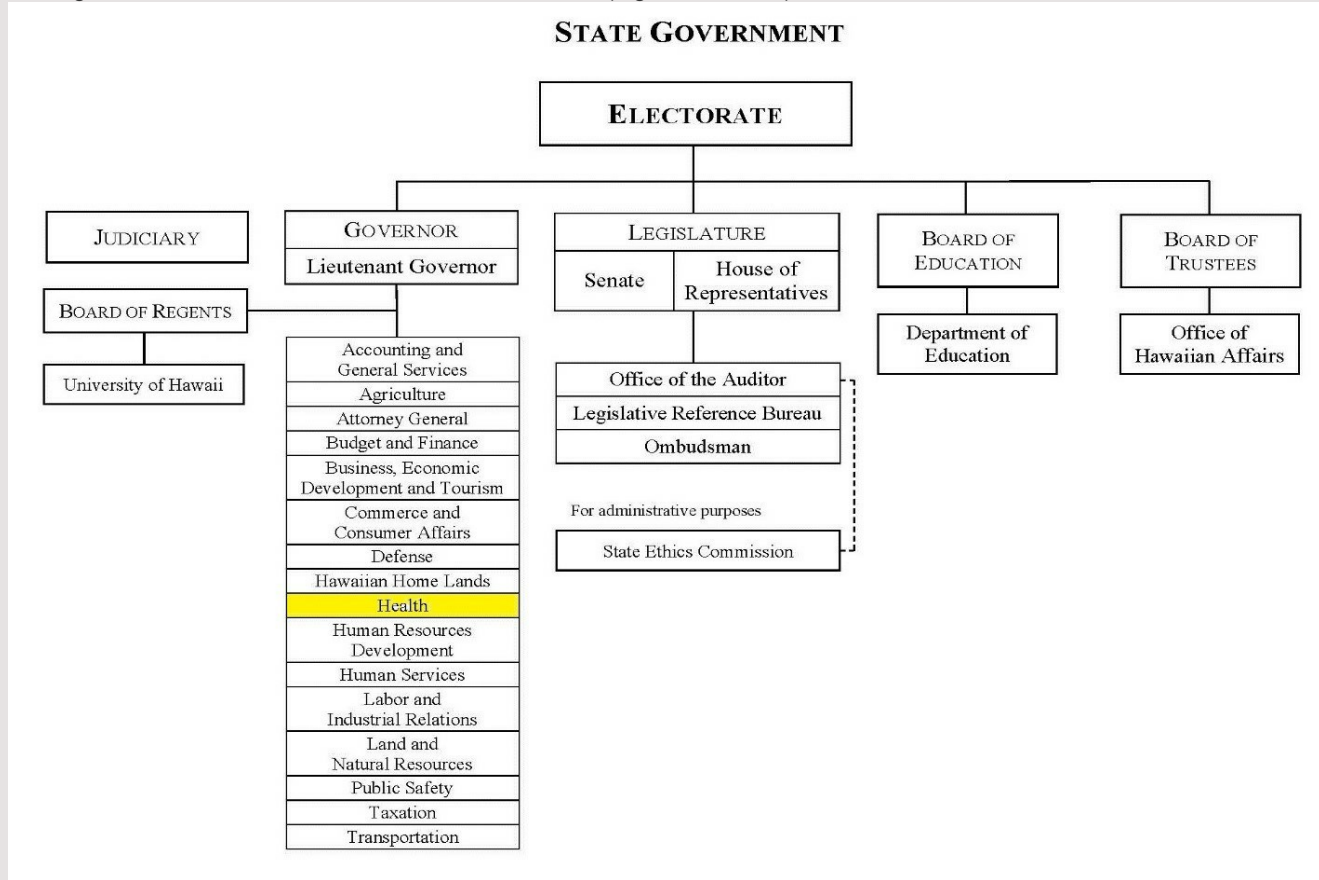


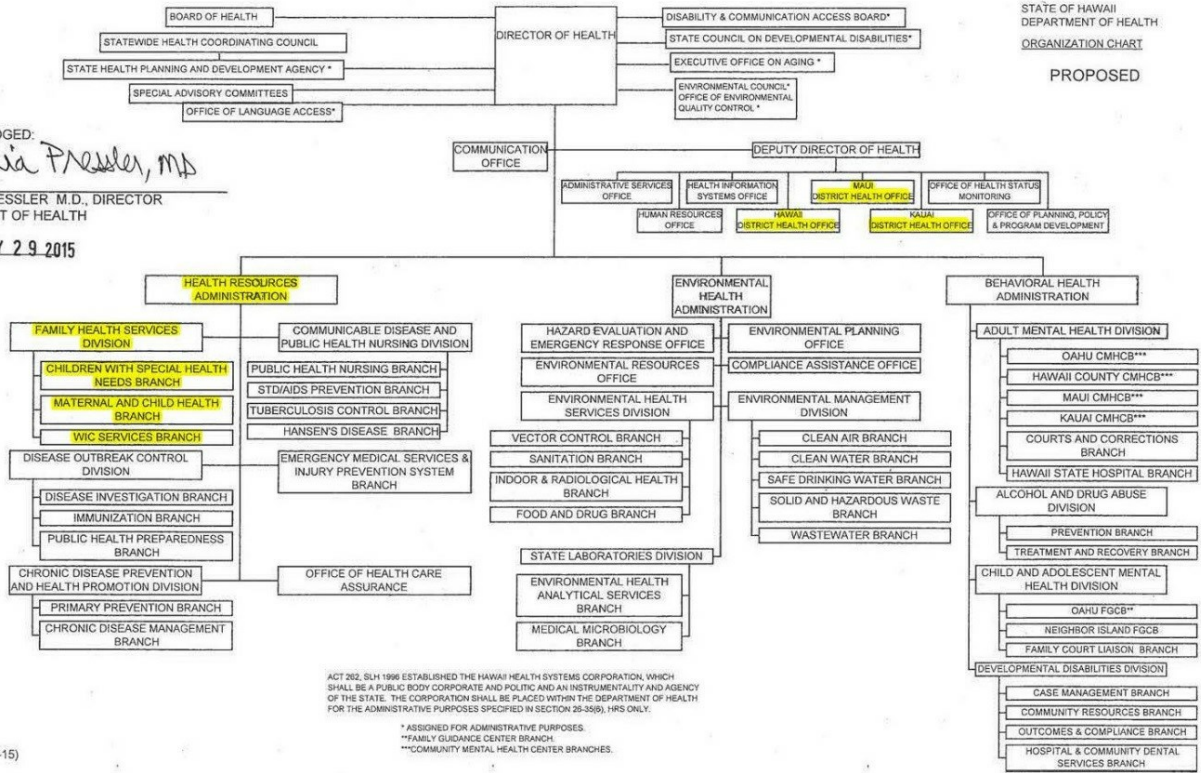
Figure 1

ACKNOWLEDGED:
Virginia Pressler, MD

VIRGINIA PRESSLER M.D., DIRECTOR
 DEPARTMENT OF HEALTH

DATE: MAY 29 2015

STATE OF HAWAII
 DEPARTMENT OF HEALTH
 ORGANIZATION CHART
 PROPOSED



ACT 262, SLH 1996 ESTABLISHED THE HAWAII HEALTH SYSTEMS CORPORATION, WHICH SHALL BE A PUBLIC BODY CORPORATE AND POLITICAL 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 25-35(5), HRS ONLY.

* ASSIGNED FOR ADMINISTRATIVE PURPOSES.
 ** FAMILY GUIDANCE CENTER BRANCH
 *** COMMUNITY MENTAL HEALTH CENTER BRANCHES.

00000000 (4-28-15)

Figure 2

ACKNOWLEDGED:

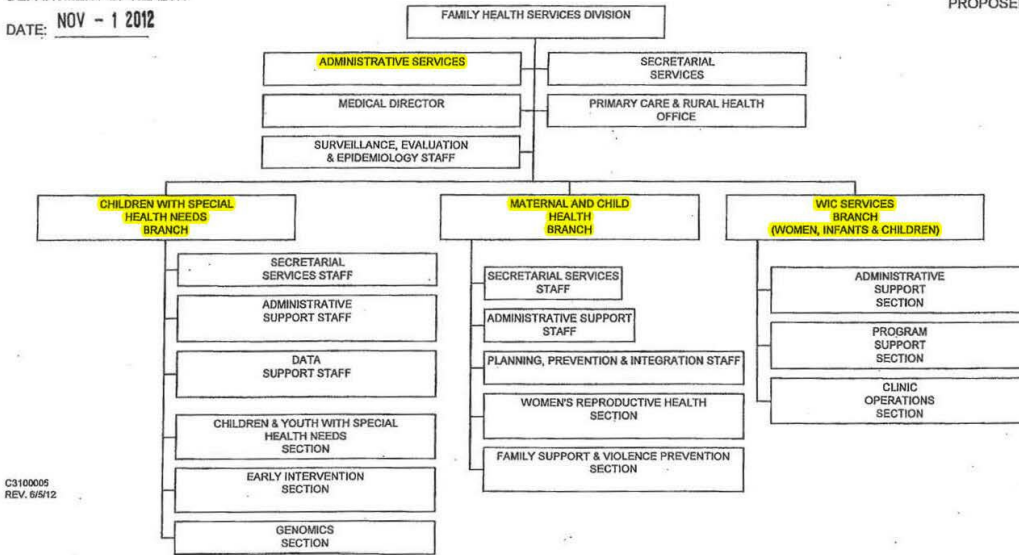

LORETTA J. FUDDY, A.C.S.W., M.P.H., DIRECTOR
DEPARTMENT OF HEALTH

DATE: NOV - 1 2012

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



C3160005
REV. 6/9/12

Figure 3

**HAWAII TITLE V PROGRAMS
BY ORGANIZATION**

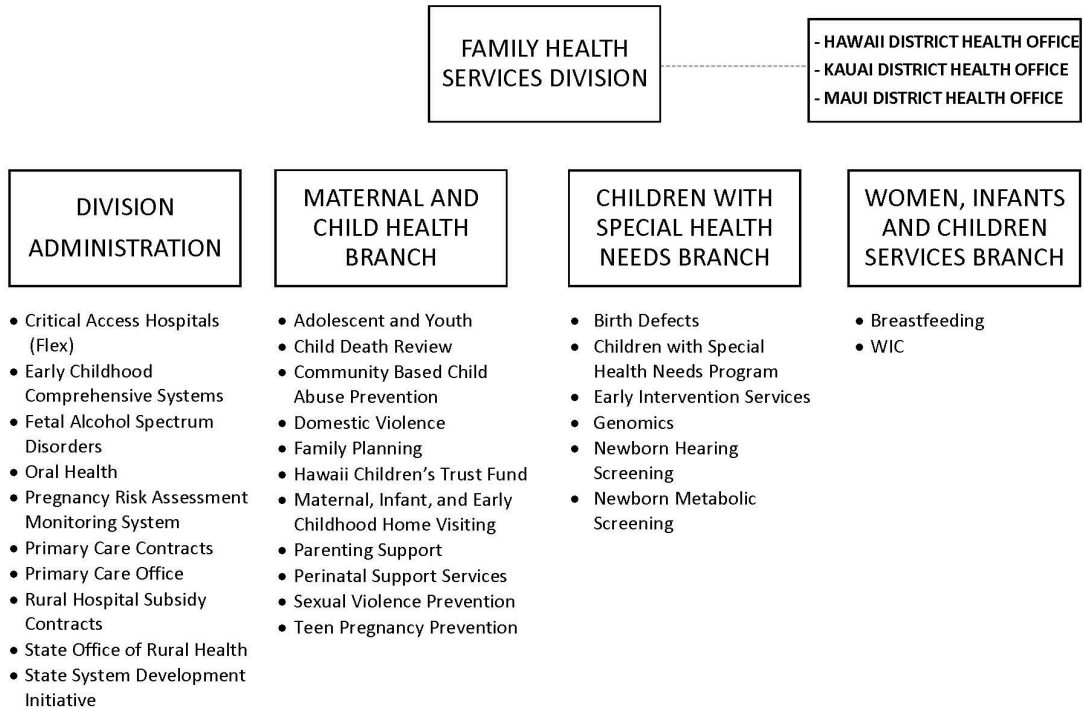


Figure 3.a.

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

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

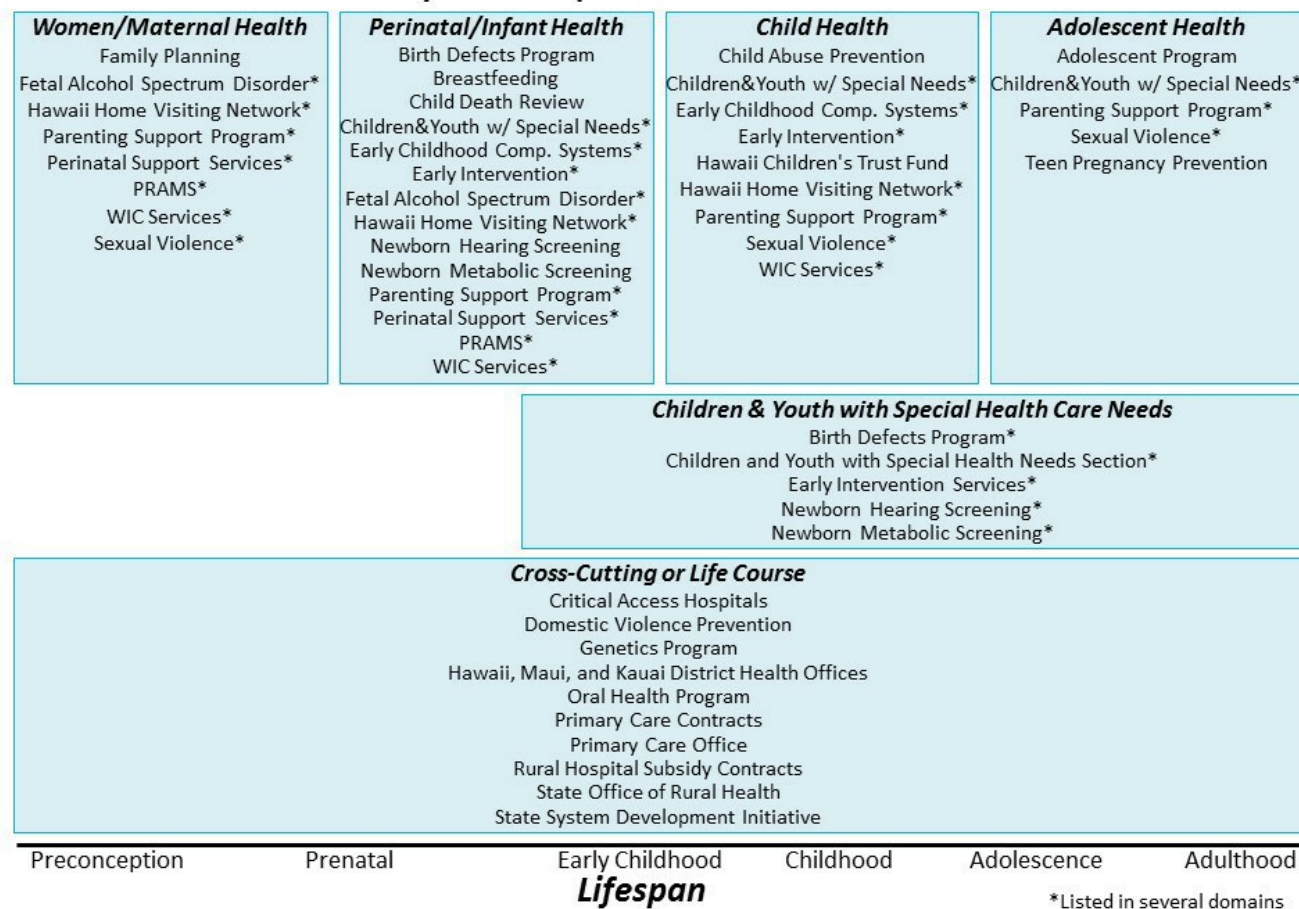
In Hawaii, Title V is considered the “umbrella” for the work of FHSD to improve the health of women, infants, children and adolescents and other vulnerable populations and their families in Hawaii.

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

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

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

Family Health Services Division Programs By Title V Population Health Domains



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

ENSURING A STATEWIDE SYSTEM OF SERVICES

State program collaboration with other agencies: Collaborations include:

- Increasing data capacity: This is a result of FHSD partnership with the DOH Office of Health Status Monitoring; investing resources into Hawaii Health Survey, PRAMS, and other health surveillance tools; and maximizing use of MCH epidemiologist. WIC, PRAMS and Birth Defects data are included in DOH Data Warehouse.
- Monitoring health through data linkages and sharing: WIC and Early Intervention Section data will be included in the statewide longitudinal data system of the University of Hawaii P-20 Data exchange Partnership. It will link child data from DOH to Hawaii K-12 public school system (Department of Education), higher education (University of Hawaii), and workforce development (Department of Labor and Industrial Relations).
- Informing, educating and empowering through partnerships and public awareness campaigns such as Child Abuse

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

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

-
State support for communities. Examples include:

- FHSD coordinators in each DHO promote MCH/CSHCN public health activities on Neighbor Islands.
- WIC, family planning, early intervention, and children with special health needs services are statewide, on all islands. Community health centers across the state are contracted to provide primary care services.
- FHSD periodically publishes a State of Hawaii Primary Care Needs Assessment Data Book to assist communities in examining their health care needs.
- Many programs provide outreach and referral through toll-free telephone warm lines, community-based health fairs, and websites with local contact numbers.
- Professional development, training and technical assistance is provided statewide.

-
Coordination with health components of community-based systems. Examples include:

- Contracts with Community Health Centers support access to prenatal care and other medical and dental services at the community level.
- Children and Youth with Special Health Needs Section provides pediatric cardiology, neurology, and nutrition clinics on the islands of Hawaii, Kauai, Maui, and Molokai where services are not available. Eligible children/youth are assisted with air/ground transportation from Neighbor Islands to Oahu pediatric specialty services as needed.
- Genetics Program, with Hawaii Community Genetics geneticists, provides genetic evaluation and counseling to families at Neighbor Island in-person clinics and telehealth clinics via videoconferencing.

-
Coordination of health services with other services at the community level: Examples include:

- DHO Family Health Services Coordinators work with their communities to coordinate health and other services.
- For FHSD contracts with community health centers, providers must respond to a core set of objectives and report on the impact of services within their respective communities.
- CSHN and Early Intervention care coordinators and other staff for State or contracted programs are expected to ensure that program services are coordinated with a child/family's other services.

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

MCH AND CSHCN WORKFORCE

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

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

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

- FAMILY HEALTH SERVICES DIVISION: FHSD Chief position has been vacant since 1/1/15 and is in the hiring process. Former FHSD Chief, Danette Wong Tomiyasu, is now Deputy Director of the Health Resources Administration. Medical Director is Louise Iwaishi, MD, and MCH epidemiologist is Don Hayes, MD, MPH. Division programs include Office of Primary Care and Rural Health, PRAMS, State Systems Development Initiative, Early Childhood Comprehensive Systems, and Fetal Alcohol Spectrum Disorder.
- CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH: Patricia Heu, MD, MPH, pediatrician, has served as the Branch Chief since 1997. Programs include Newborn Hearing Screening, Newborn Metabolic Screening, Children with Special Health Needs, Early Intervention, Genetics, and Birth Defects Programs.
- MATERNAL AND CHILD HEALTH BRANCH: Branch Chief position has been vacant since 3/20/15 and is the hiring process. Programs include Family Strengthening and Violence Prevention, Home Visiting Services, Child Death Review, Reproductive Health Services, Women's Health Clinical and Quality Assurance, and Adolescent Health programs.
- WIC SERVICES BRANCH. Linda Chock, MPH, RD, has served as WIC Director and Branch Chief since 1997. Programs include Breastfeeding.
- DISTRICT HEALTH OFFICES (DHOs): DOH programs on the Neighbor Islands are administered by three DHOs for Hawaii, Maui, and Kauai Counties. Each DHO has a Family Health Services Coordinator responsible for FHSD services (Children with Special Health Needs, Early Intervention, Maternal and Child Health, WIC). Each office may also have other responsibilities and have projects/activities specific for their communities.
- TITLE V FAMILY LEADER: Leolinda Parlin has been active in the needs assessment process and planning of Title V MCH/CSHCN priorities and activities for many years. She is the parent of a young man with special needs; Director, Hilopaa F2FHIC; Co-Director, Hawaii MCH LEND Program; Coordinator, Family Voices of Hawaii; Family Delegate, Association of MCH Programs.

Needs and challenges:

- Vacancies for key leadership positions, with a lengthy hiring process.
- Difficulty in filling Title V funded positions, due to insufficient Title V funding. There has not been an increase in Title V funding to correspond with salary increases.

- Difficulty in requesting new State general funded positions due to State economic concerns.
- Difficulty in filling federal grant funded positions due to a lengthy process.
- FHSD is still adjusting to the loss of a significant number of positions with the Reduction in Force of 2009 and other personnel action, which resulted in the abolishment of 76.75 permanent positions within FHSD (21.0% staffing reduction).

CULTURALLY COMPETENT APPROACHES

Promoting culturally competent approaches in service delivery include:

- Collection and analysis of data by different ethnic groups. FHSD Profiles 2014 includes data by race/ethnicity for infant mortality, preterm births, and adults with no regular primary care provider. PRAMS data have been analyzed by race/ethnicity for perinatal alcohol use, perinatal smoking, breastfeeding, and other areas.
- Diverse ethnic groups are represented by FHSD leaders/staff; State and community leaders and participants for various committees, task forces, and collaboratives; and family representatives.
- FHSD service contracts include a requirement for providers to comply with state and federal laws regarding language access, including linking clients/families with interpreter services if they do not speak English as their primary language and have a limited ability to read, write, speak, or understand the English language. FHSD contracts also require the provision of sign language interpretation when the primary caregiver needs it.
- FHSD staff follow the same state and federal laws regarding language access.
- FHSD staff participate in Office of Language Access conferences and other trainings.

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

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

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

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

Other federal investments:

- Administration for Children and Families (ACF) provides funds for the MCH Branch's Community Based Child Abuse Prevention (CBCAP) grants and Personal Responsibility Education Program. FHSD also collaborates on child care issues with the Hawaii Department of Human Services which houses the Child Care Development Block Grant.
- CDC provides funding for Oral Health Program, and PRAMS. FHSD staff collaborate with the CDC Act Early Ambassador (University of Hawaii/Center on Disability Studies). CDC also deploys to FHSD an MCH Epidemiologist position that is paid through Title V.
- U.S. Department of Agriculture provides funding for the WIC Branch.

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

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

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

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

Other government agencies: FHSD works with other departments including:

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

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

Family/consumer partnership and leadership programs:

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

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

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

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

III.D. Financial Narrative

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$2,144,047	\$1,390,506	\$2,156,997	\$1,213,952
State Funds	\$25,217,539	\$22,376,536	\$28,911,631	\$26,442,167
Local Funds	\$0	\$0	\$0	\$0
Other Funds	\$75,000	\$6,359	\$75,000	\$0
Program Funds	\$19,172,085	\$11,342,262	\$16,520,311	\$12,356,042
SubTotal	\$46,608,671	\$35,785,921	\$47,663,939	\$40,640,408
Other Federal Funds	\$45,034,232	\$0	\$54,186,151	\$31,816,371
Total	\$91,642,903	\$35,785,921	\$101,850,090	\$72,456,779

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$2,176,627	\$1,998,893	\$1,989,226	
State Funds	\$29,083,184	\$24,722,002	\$28,414,686	
Local Funds	\$0	\$0	\$0	
Other Funds	\$75,000	\$47,719	\$63,078	
Program Funds	\$16,745,817	\$10,892,484	\$16,422,876	
SubTotal	\$48,080,628	\$37,661,098	\$46,889,866	
Other Federal Funds	\$55,420,856	\$44,210,716	\$49,970,074	
Total	\$103,501,484	\$81,871,814	\$96,859,940	


	2019	
	Budgeted	Expended
Federal Allocation	\$2,394,340	
State Funds	\$28,350,378	
Local Funds	\$0	
Other Funds	\$0	
Program Funds	\$13,205,575	
SubTotal	\$43,950,293	
Other Federal Funds	\$51,294,329	
Total	\$95,244,622	

III.D.1. Expenditures

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

Overview of FHSD Programs

As noted earlier, the Hawaii DOH is the only public health agency in the state. Thus, unlike other states, FHSD must provide all levels of service delivery: direct, enabling, and infrastructure building for all the counties. One of the largest Divisions in DOH, FHSD’s 3 branches—Maternal and Child Health (MCH), Children with Special Health Needs (CSHN), and Women, Infants & Children (WIC) Services; together, addressed this need with a FY 2017 budget of \$103.5M and expenditures of \$89.9M. The funds supported the Division’s 30 programs and allowed for the execution of approximately 150 service contracts with community based organizations throughout the state totaling roughly \$50M. The table below list the FHSD programs by Division and Branch.

 FAMILY HEALTH SERVICES DIVISION (FHSD)		HAWAII DISTRICT HEALTH OFFICE KAUAI DISTRICT HEALTH OFFICE MAUI DISTRICT HEALTH OFFICE	
DIVISION ADMINISTRATION	MATERNAL AND CHILD HEALTH BRANCH	CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH	WOMEN, INFANTS AND CHILDREN SERVICES BRANCH
<ul style="list-style-type: none"> • Critical Access Hospitals (Flex) • Early Childhood Comprehensive Systems • Oral Health • Pregnancy Risk Assessment Monitoring System • Primary Care Office • Rural Health Office • Title V Maternal and Child Health • Primary Care & Hospital Subsidies 	<ul style="list-style-type: none"> • Adolescent Wellness • Child Abuse and Neglect, Domestic and Sexual Violence Prevention • Child Death Review • Domestic Violence Fatality Review • Family Planning • Hawaii Home Visiting • Maternal Mortality Review • Women’s Health Clinic and Quality Assurance 	<ul style="list-style-type: none"> • Birth Defects • Childhood Lead Poisoning Prevention • Children and Youth with Special Health Needs • Early Childhood • Early Intervention • Genetic Services • Hi’ilei Hawaii Developmental Follow Along for Young Children • Newborn Hearing Screening • Newborn Metabolic Screening 	<ul style="list-style-type: none"> • Breastfeeding Peer Counseling • Special Supplemental Nutrition Program for Women, Infants & Children (WIC)

The work of the Division is conducted by 277 FTE positions statewide funded by both federal and state funds; 46 FTE are located on the smaller ‘neighbor island’ counties through county district health offices (DHO) on Kauai, Maui, Hawaii. Each DHO FHSD program is overseen by a Nurse Manager, who supervises both WIC, CSHN, and Early Intervention Services staff.

Federal Funds. FHSD maintains one of the most diverse funding sources in the DOH, nearly evenly split between federal and state funds. In FY 2017 Federal sources include 23 federal grants totaling \$57.8M (with the Title V Block Grant). A list of federal grants by agency can be found in Form 2 for FY17. Note that although only 20 grants are listed, the WIC services’ branch administers three Department of Agriculture separate grants for WIC services breastfeeding support, and data system improvements; however, all three grants are listed as one grant. Similarly,

the MIECHV program is funded by two separate federal grants that provides base funding and expansion services. The Title V allocation was \$2.2M in FY17, roughly 3.8% of all federal funds and 2.0% of the total FHSD budget.

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

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

Note that many of the federal grants require matching state funds, thus the programs are reflected in the budget/expenditures under both 'Other Federal Funds' and the state match. The FY 2017 list includes the federal Abstinence Education grant; however, program services were completed in FY 2016 and is not discussed in the report narrative.

State Funds. FY 2017 state funds totaled \$29.1M largely general funding for personnel and operations (including funding for direct services). A portion of the state funds includes Program Income (Form 2, Line 6) in FY 2017 amounting to \$16.7M. This income is managed through five state 'special funds'. These special funds are:

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

Clients Served. Form 5a reports on the number of clients receiving direct or enabling services with Title V and state matching funds. The total served is 39,546, broken out as follows:

Pregant women: 1,307
 Infants 609
 Children 15,832
 CSHN 7,330

Others 21,798.

Form 5b estimates FHSD programs using all funding sources were able to reach: 48% of the pregnant women, 100% of all infants, 12% of children 1-21 years of age, 17% of children with special health needs and 4% of others.

Use of Title V Funds. To support the infrastructure needed to administer FHSD programs statewide, Title V funds are used for key staff positions (18.1 FTE out of a total of 277 FTE) including an epidemiologist, branch research statisticians, MCH and CSHN program managers, a pediatric medical director, nurses, a nutritionist, an audiologist, contract manager, and general office support. These positions are critical to securing, leveraging, and managing FHSD's statewide service system, its broad array of funding sources, addressing statewide surveillance needs, developing critical statewide partnerships, improving quality to assure services are family-centered, culturally competent, and community based.

Legislative Requirements Met. The State maintains expenditure and budget documentation for all MCH Block Grant funding allocations for tracking and reporting. Consistent with the requirements in the Title V legislation, expenses are tracked through the state's accounting system, *Datamart*. The FHSD program undergoes an annual audit required for all State departments.

The Title V legislation also requires a minimum of 30% of block grant funds to be used for preventive and primary care services for children and at least another 30% for services for CSHCN. No more than 10% of the grant may be used for administration. Form 2, reports Hawaii has met these requirements for FY 2017 expenditures. The table below outlines the FY 2017 budget and expenditures across these categories. Preventive/Primary care for children was 31.3% of FY 17 Title V expenditures; while CSHCN received 36.9% of Title V funds in the same year. Hawaii is able to keep administrative costs low (2.0%) because DOH waives all indirect costs for the Title V grant.

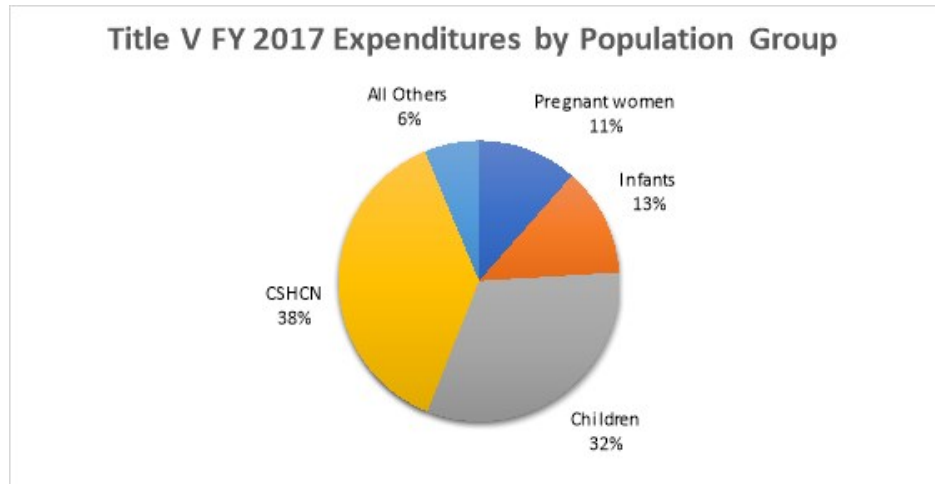
Category	FY 17 Budgeted		FY 17 Expended	
Preventive and Primary Care for Children	\$778,528	35.8%	\$626,838	31.3%
Children with Special Health Care Needs	\$761,805	35.0%	\$739,468	36.9%
Title V Administrative Costs	\$191,301	8.8%	\$38,229	2.0%

Lastly, the state must meet a maintenance of effort with a state match equal to levels in 1989. With the exponential growth of FHSD since 1989 the state match of \$35.7M far exceeds the match requirement.

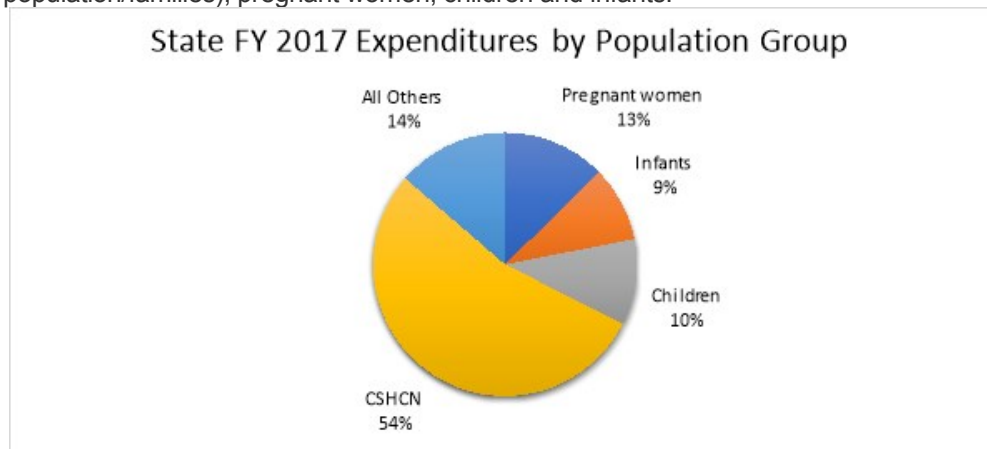
New Methodology for Reporting. FHSD has new fiscal staff who are implementing a different methodology to report Title V budget and expenditures that reflects a more accurate description of funds by Title V reporting categories. In previous years, expenditures (and budgets) were grossly assigned to categories using program budgets/expenditures. This year, fiscal staff worked in conjunction with the FHSD management team to calculate expenditures for Title V personnel based on program purpose as well as job functions. A detailed spreadsheet was developed to capture this information. Detailed breakouts were also developed for state funded programs and personnel. This new methodology may account for some variances on this year's application. The new methodology will be maintained from this application moving forward and the variances should diminish over time.

Expenditures by Population Group. The chart below shows how the FY 2017 \$1.9M Title V funds were expended to serve the five Title V population groups. The amounts reflect expenditures for Title V funded personnel (18.1 FTE) to support FHSD programs across the state and \$10K for the state MCH hotline. No Title V funds were used for

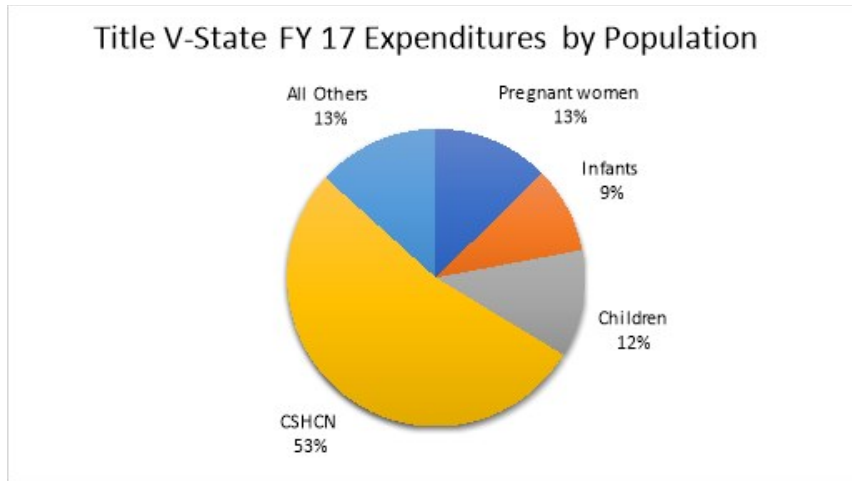
direct services. The breakouts confirm Hawaii expended over 30% for CSHCN (38%) and children (32%), followed by infants (13%), pregnant women (11%) and others (6%).



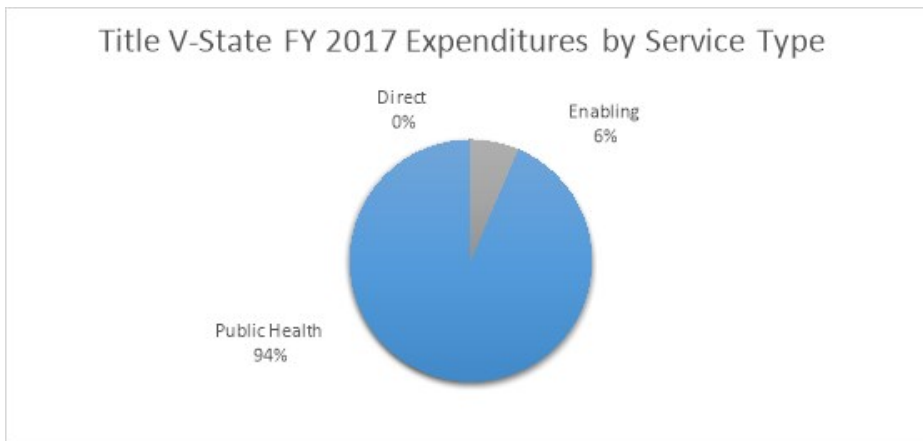
The chart below shows how the FY 2017 \$35.7 state matching funds were expended to serve the five Title V population groups as reported on Form 3a, IB, Non-Federal MCH Block Grant. The amounts reflect costs for both personnel and operating (including contracts for service delivery). Over half of FHSD's state funds were dedicated to serve CSHCN (54%). The remaining budget was evenly divided by the remaining four populations groups: All Others (general adult population/families), pregnant women, children and infants.



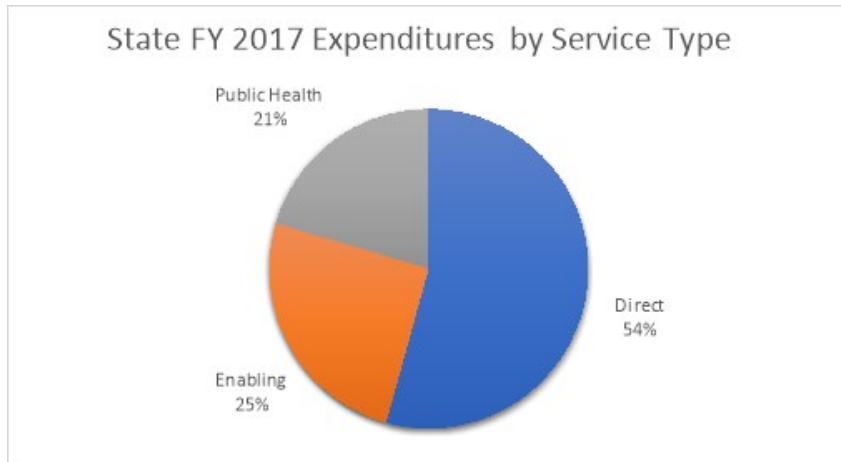
The chart below illustrates how both Title V and State matching funds in FY 2017 (\$37.6M) were expended to serve the five Title V population groups as reported on Form 3a. Over half of FHSD's state funds were dedicated to serve CSHCN (53%). The remaining budget was divided fairly evenly by the remaining four populations groups by All Others (13%), followed by pregnant women (13%), children (12%) and infants (9%).



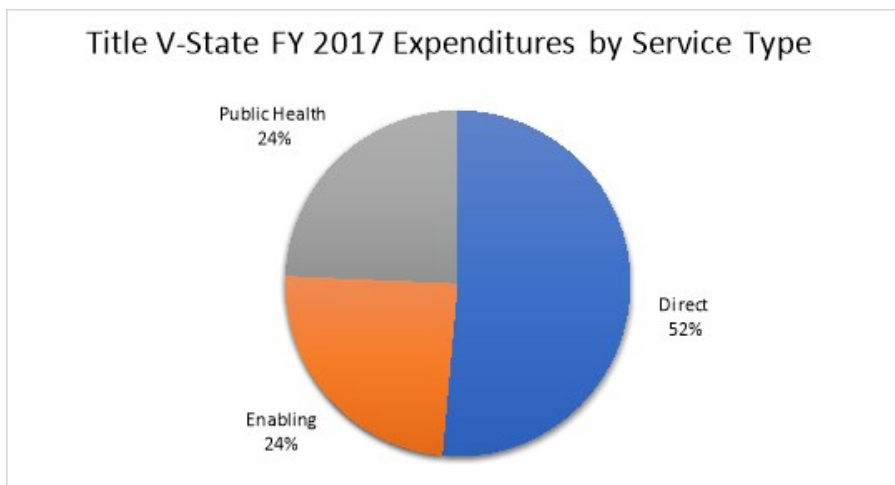
Expenditures by Type of Service. The chart below shows how the FY 2017 \$1.9M Title V funds were expended by type of service as defined by the Title V guidance: direct, enabling, and public health services and systems. The amounts reflect expenditures for Title V-funded personnel that support FHSD programs across the state and \$10K for the state hotline. The chart shows no Title V funds are used for direct services and nearly all funds are used for public health and systems building (94%).



The chart below shows how the FY 2017 \$35.7 state matching funds were expended by type of service as reported on Form 3b, IIB, Non-Federal MCH Block Grant. The amounts reflect costs for both personnel and operating (including contracts for service delivery). Over half of FHSD's state funds are used for direct service primarily CSHCN. The remaining state expenditures were evenly divided between enabling and public health services. Hawaii clearly relies on Title V funding to provide infrastructure support for its MCH programs.



The chart below shows how both Title V and State matching funds in FY 2017 (\$37.6M) were expended by type of service as reported on Form 3b. Over half of FHSD's state funds were dedicated to direct services (52%). The remaining budget was divided evenly by public health services (24%) and enabling services (24%).



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

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

Significant Variations – Form 2 and Form 3 (Fiscal Year 2017) - Expenditures

Form 2, Item 1A. Earmark for Preventive and Primary Care for Children. The amount budgeted in this category for fiscal year 2017 was \$778,528, however the amount actually expended was \$626,838, a difference of \$151,690. This variance is primarily due to salary and fringe benefit savings from vacancies. FHSD did not fill several vacant Title V funded positions to ensure that there were sufficient funds to meet salary, fringe benefit, and operating cost in federal fiscal year 2017.

Form 2, Item 1C. Title V Administrative Cost. The budgeted amount for this category in fiscal year 2017 was \$191,301, and the actual amount expended from the fiscal year 2017 was \$38,229, a difference of \$153,072. As mentioned in the opening paragraph, FHSD is using a new methodology for calculating expenditures from the FY17 budget year moving forward. Title V Administrative Costs, as calculated using the new methodology, can only be attributed to the FHSD Title V funded Administrative Officer V position. In 2017, the FHSD Administrative Officer V position was vacant for a portion of the year. The variance in budgeted versus actual expenditures for the Title V Administrative Cost in FY2017 is primarily attributed to a change in methodology for calculations and the partial vacancy of the position which was used to calculate this category.

Form 2, Item 3. State MCH Funds. The category "State MCH Funds" was \$29,083,184 in fiscal year 2017, and the amount actually expended was \$24,722,002, a difference of \$4,361,182. This difference is attributed to outstanding unliquidated encumbrances as of September 30, 2017.

Form 2, Item 5. Other Funds. The budgeted amount for the category "Other Funds" was \$75,000 in fiscal year 2017 but there were no actual expenditures due to the elimination of the Child Death Review Coordinator position. The State Department of Human Services, Social Services Division's was no longer able to fund the position. A request to the FY17 legislature to fund the Child Death Review program was approved for the FY18 budget and appropriated in general funds (rather than Other Funds). FHSD anticipates filling this general fund position in FY19 and reflect CDR funding under the general state fund match.

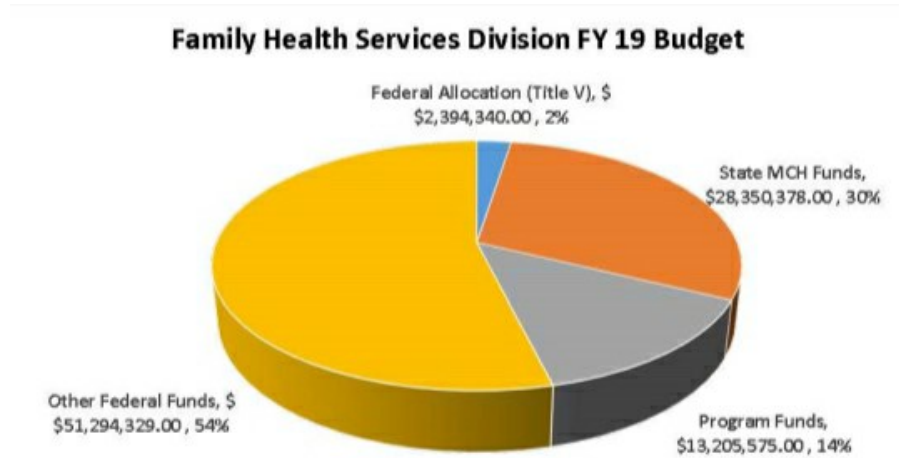
Form 2, Item 6. Program Income. The amount budgeted for this category in fiscal year 2017 was \$16,745,817 and the amount actually expended was \$10,892,484. The reason for the difference is that the authorized budget ceilings for the Community Health Centers Special Fund, Early Intervention Special Fund, and the Domestic Violence and Sexual Assault Special Fund is higher than the revenues being deposited into these accounts. Annual expenditures are congruent with the revenues being deposited and are not aligned with the authorized budget ceilings for these special fund accounts. FHSD will modify budget reporting for Program Income to eliminate this disparity in the future.

III.D.2. Budget

Every day, the Hawaii State Department of Health (DOH), Family Health Services Division (FHSD) works to improve the health of women, children and families throughout the state. FHSD achieves this work through its Division, Branch, and District Health Offices; 30 programs, nearly 150 service contracts, and in FY 2019 a \$95.2M budget.

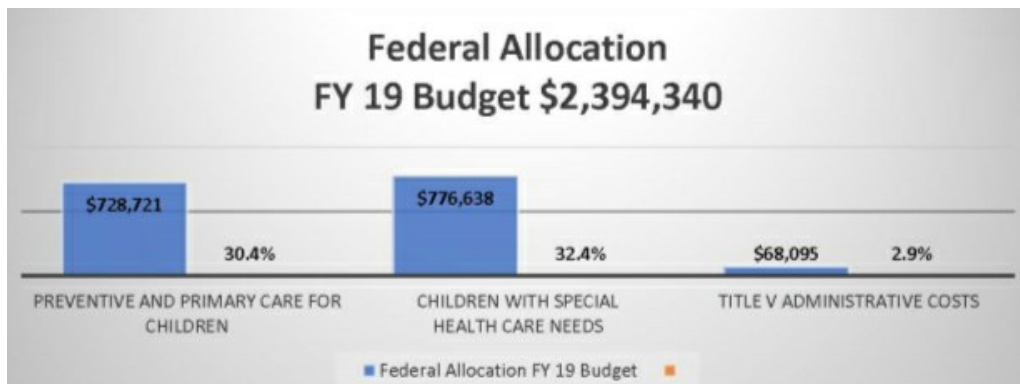
Budget Overview

The chart below provides a quick overview of FHSD’s FY19 Budget as reported on Form 2. The \$95.2 M FY19 budget is comprised of nearly \$2.2M from Title V; a state match of \$41.6M (which includes Program Income of \$13.2M) and Other Federal Funds totaling \$51.3M.



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

FHSD is committed to comply with the legislative financial requirements that a minimum of 30% of Title V funds are used for preventive and primary care services for children; at least another 30% for services for CSHCN; and no more than 10% of the grant may be used for administration. For FY19, Hawaii is distributing \$728,721 (30.4%) for Preventive and Primary Care for Children, \$776,638 (32.4%) for CSHCN, and \$68,095 (2.9%) for Title V Administrative Costs as reported on Form 2, Lines 1. A, B, and C.



Federal Funds. The FY 2019 Other Federal sources includes 23 federal grants totaling \$51.3M (without Title V). The Title V allocation is \$2.4M roughly 4.5% of all federal funds and 2.5% of the total FHSD budget.

The overall FHSD budget decreased significantly since FY 2017 largely due to the loss of \$4M in WIC services funding after successive years of decreased caseloads. Hawaii is following a national trend among state WIC programs. While a portion of the decrease reflects the state's improved economic situation, WIC is addressing some of the reasons for the decrease through outreach, streamlining administrative processes, and greater integration/collaboration with existing community based service providers.

Other changes to federal funding include Hawaii electing to drop the abstinence education grant and the end of federal Zika funding. The FY 2019 budget does include a new Centers for Disease Control and Prevention (CDC) Childhood Lead Poisoning Prevention grant. A list of the FY 2019 federal grants by agency can be found in Form 2.

As noted, FHSD is heavily reliant on federal funding (half the total budget). Most of the grants pay for positions to manage and administer these federally funded programs. However, most of the grants provide level funding over a period of year which creates budget challenges as programs costs increase. Operating and personnel costs for federal grants like Title V, Pregnancy Risk Assessment Monitoring System (PRAMS), Primary Care Office (PCO), and Rural Health are beginning to exceed the federal grant award. Collective bargaining agreements for public employees assures nearly annual increases in salaries and fringe benefits at the same time operational expenses also increase. FHSD requested and received in some cases a waiver of indirect costs. This is the case for Title V, thus keeping administrative costs low. FHSD leveraged its funding from other grants to cover costs, sought state funds, or has not filled positions when they are vacated through retirement or attrition. FHSD also elected to redescribe positions from high salary medical professionals (i.e. nurses) to public health program specialists.

State Funds. FY 2019 state funds budget totals \$41.6M largely general funding for personnel and operations (including funding for direct services). Program Income is \$13.2 in FY 2019 partially due to decreases in the cigarette tax collections for the Community Health Centers Special Fund.

Leveraging Resources. FHSD continues to leverage resources through national, state and community partnerships. This is particularly true with the use of Title V funding which supports staffing that provide public health infrastructure services for the Divisions programs. The 18.1 Title V funded FTE positions are critical to securing, leveraging, and managing a broad array of funding sources, addressing statewide surveillance needs, developing critical statewide partnerships, improving quality to assure services are family-centered, culturally competent, and community based.

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

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

Because the DOH is the only public health agency in the state, the absence of local, city, and county health departments in Hawaii requires a disproportionate amount of infrastructure personnel within FHSD to strategically plan and administer resources statewide. The Title V MCH Block Grant provides a critical source of funding for

FHSD infrastructure positions. In FY 2017, for example, the Title V funded positions provided critical support to secure new federal and state funding for needed programs and services to reinstitute the Child Death Review, establish a Maternal Mortality Review and receive a new Lead Poisoning Screening and Prevention grant. Services included data analysis, program planning, grant writing and development of policy briefs to obtain the new funding.

Another example of leveraging Title V funding is found in the distribution of the funding to support key positions in FHSD. Title V is used to fund 80% of the Division's lead Epidemiologist, a CDC-Assignee who is also a M.D. CDC provides the other 20% of funding for the position. The CSHN Branch Chief, also a pediatric M.D., is funded 75% with Title V and 25% Part C funding. She also supervises Hawaii's Part C Early Intervention Services program as part of the CSHN Branch. A portion of both grants are used to support this critical management and medical professional position for FHSD.

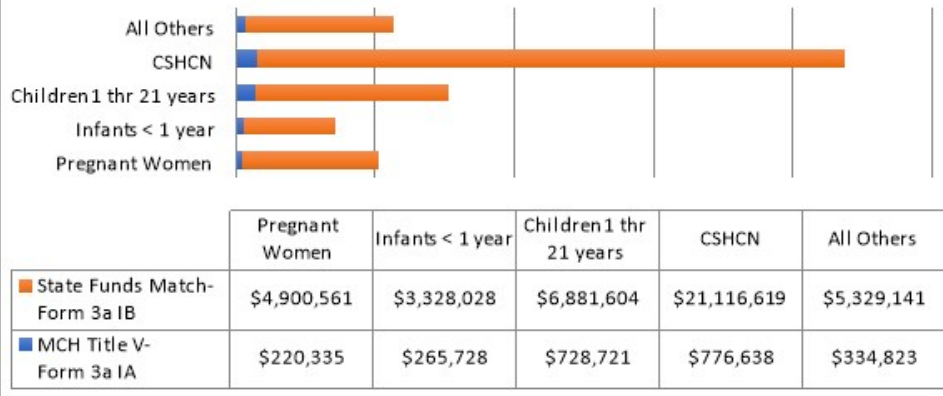
The program and staff support for the Title V priorities reflect the diversity in the FHSD budget and the importance of leveraging program funding to support the priorities. FHSD uses both state and federal funding to support the work on the priority issues. The table below summarizes the funding for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

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

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

Form 3a, *Budget and Expenditure Details by Types of Individuals Served, FY19 Application Budgeted*, demonstrates the federal and non-federal FY19 application budget. The chart below shows the state and federal breakout of planned resource allocation for each of the five population health domains. The 2019 Title V Federal Allocation budget of \$2.3M and a State Match of \$41.56M create a Federal-State Title V Partnership budget of nearly \$44M. The combined resources form the funding base for strategic collaborations with community providers and partners statewide. Annually, FHSD administers approximately 150 contracts with community organizations that serve Hawaii's MCH population. These vendors include Federally Qualified Health Centers, hospitals, private and non-profit providers in urban and rural communities throughout the state. The funds help to build community and statewide capacity to assure availability of services for Hawaii's families.

Type of Individuals Served per FY 19 Budget



FHSD will continue efforts to ensure statewide infrastructure for needs assessment, surveillance, planning, evaluation, systems/policy development, training, and technical assistance to assure quality of care into the 2019 budget year.

Significant Variations – Form 2 and Form 3 (Fiscal Year 2019) - Budget

Form 2, Item 1C. Title V Administrative Costs. The amount budgeted for this category in the fiscal year 2018 application was \$190,447, and the amount budgeted for this category in the fiscal year 2019 application is \$68,095. The decrease of \$122,352 is due to a change in methodology for calculating this category. Moving forward, the Title V Administrative Costs are allocated for the FHSD Administrative Officer (AO) V position. A state funded Division accountant and AO also assist with managing Title V funding. For reporting consistency, the new methodology will be maintained from this application moving forward.

Form 2, Item 6. Program Income. The category “Program Income” decreased from \$16,422,876 in fiscal year 2018 to \$13,205,575 in fiscal year 2019. The decrease of \$3,217,111 is due to a change in methodology for calculating this category. The variance is primarily due to calculation methodology changes from the FY19 budget moving forward.

Form 3a, IA, 1. Pregnant Women. The Federal MCH Block Grant budgeted in FY19 decreased to \$220,335 from \$532,111 in FY18. The \$311,776 decrease is due to calculation methodology changes from the FY19 budget moving forward. The primary difference in methodology from what was used in years past is that rather than calculating expenditures based on program activities as they relate to the five population domains (Pregnant Women, Infants Less than 1 Year, Children 1 through 21 Years, CSHCN, All Others) and the 30% – 30% – 10% requirements reporting is now based on a calculation of the percentage of job function that FHSD Title V funded positions allocated to the five population domains and the 30% – 30% – 10% requirements.

Form 3a, IA, 2. Infants < 1 year. The Federal MCH Block Grant budgeted in FY19 increased to \$265,728 which is \$223,690 more than was budgeted in FY18. The variance is primarily due to calculation methodology changes from the FY19 budget moving forward.

Form 3a, IA 5. All Others. The Federal MCH Block Grant budgeted in FY19 is \$334,823 compared to \$0 in FY18. The variance is primarily due to calculation methodology changes from the FY19 budget moving forward.

Form 3a, IB, 3. Children 1 through 21 Years. The Non-Federal MCH Block Grant budget for Children 1 through 21 Years in FY19 is \$6,881,604 or \$2,607,408 less than was budgeted in this category in FY18. The variance is primarily due to calculation methodology changes from the FY19 budget moving forward.

Form 3a, IB, 5. All Others. The Non-Federal MCH Block Grant budget for All Others in FY19 is \$5,329,141. The \$1,659,290 decrease is primarily due to calculation methodology changes from the FY19 budget moving forward.

Form 3b. IIA. 2. Enabling Services. The Federal MCH Block Grant budget for Enabling Services was \$472,493 in FY18 but only \$133,392 in FY19. The \$339,101 decrease can be attributed to a change in the methodology used to calculate FY19 budget.

Form 3b. IIA. 3. Public Health Services and Systems. The Federal MCH Block Grant budget for Public Health Services and Systems was \$1,707,180 in FY18. The FY19 budget for this category increased by \$553,768 to \$2,260,948. The increase is primarily due calculation methodology changes from the FY19 budget moving forward.

III.E. Five-Year State Action Plan

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

State: Hawaii

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

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

Women/Maternal Health

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

Priority Need

Promote reproductive life planning

NPM

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

Objectives

By July 2020, increase the percentage of women ages 18 through 44 who had a preventive medical visit in the past year to 65% (Baseline: 2013 Behavioral Risk Factor Surveillance System (BRFSS) data 62.3%)

Strategies

Promote women's wellness through systems building efforts

Promote pre/inter-conception health care visits

Promote reproductive life planning

ESMs

Status

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

Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

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

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

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

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

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Perinatal/Infant Health

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

Priority Need

Reduce the rate of infant mortality

NPM

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

Objectives

By July 2020, increase the percent of infants who are ever breastfed to 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

Partner with community-based organizations to promote and support breastfeeding

Promote collaboration and networking

ESMs

Status

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

Active

NOMs

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

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

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

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

Priority Need

Reduce the rate of infant mortality

NPM

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

Objectives

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

Strategies

Policy Development: Implementation of safe sleep policies

Assure competent workforce

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

ESMs

Status

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

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

Child Health

State Action Plan Table (Hawaii) - Child Health - Entry 1

Priority Need

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

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

By July 2020, increase the percent of children, ages 10 months 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

Family Engagement and Public Awareness

Data Integration

Policy and Public Health Coordination

Social Determinants of Health and Vulnerable Populations

ESMs

Status

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

ESM 6.2 - Develop and Implement Policy and Public Health Coordination (PPHC) rating scale to monitor infrastructure development within FHSD. Active

NOMs

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Priority Need

Improve the oral health of children

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

By July 2022, increase the percent of children, ages 1 through 17 who had a preventive dental visit in the past year to 87% (Baseline: 2016 NSCH data 83.1%)

Strategies

Develop program leadership and staff capacity

Develop or enhance oral health surveillance.

Assess facilitators/barriers to advancing oral health

Develop and coordinate partnerships with a focus on prevention interventions

Develop plans for state oral health programs and activities

ESMs

Status

ESM 13.2.1 - The establishment of leadership for the State Oral Health Program under the direction of a dental professional and staff with public health skills. Inactive

ESM 13.2.2 - Completion of teledentistry pilot project at three early childhood settings to reach underserved children. Active

NOMs

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Priority Need

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

SPM

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

Objectives

By July 2023, reduce the rate of confirmed child abuse and neglect cases per 1,000 for children to 5.8 per 1,000 (New objective: baseline 6.1 in 2017)

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.

Develop child abuse and neglect surveillance system

Adolescent Health

State Action Plan Table (Hawaii) - Adolescent Health - Entry 1

Priority Need

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

NPM

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

Objectives

By July 2020, increase the percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year to 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.

Youth and Family Engagement/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, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Children with Special Health Care Needs

State Action Plan Table (Hawaii) - Children with Special Health Care Needs - Entry 1

Priority Need

Improve the percentage of youth with special health care needs ages 12-21 years who receive services necessary to make transitions to adult health care.

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

By July 2020, increase the percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care to 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), ages 0 through 17, who receive care in a well-functioning system

Cross-Cutting/Systems Building

State Action Plan Table (Hawaii) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Improve access to services through telehealth

SPM

SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers.

Objectives

By July 2020, 100% of Title V programs use telehealth to provide services, education, and/or training.

Strategies

Telehealth infrastructure development: - Recruit staff from Title V programs and partners to form telehealth work group. - Develop and implement policies and procedures for telehealth in Title V programs. - Develop network of telehealth sites and personnel.

Workforce development: - Develop curriculum to train staff on the use of telehealth. - Implement training for staff. - Continuously evaluate training to make improvements to curriculum. - Implement long term follow-up of trainees to determine usefulness and use of training in their work.

Service Provision: - Identify services to be provided using telehealth. - Develop, implement, and evaluate pilot programs to implement telehealth for identified service. - Expand successful pilot programs

Education/Training: - Identify education and training to be provided using telehealth. - Develop, implement and evaluate pilot programs to implement telehealth for identified education and training. - Expand successful pilot programs.

III.E.2. State Action Plan Narrative Overview

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

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

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

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

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

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

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

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

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

The **Women, Infants, and Children (WIC)** Special Supplemental Nutrition Program is a \$29M United States Department of Agriculture (USDA) Food and Nutrition Service (FNS) federally funded short-term intervention program. USDA FNS provides Federal grants to States for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk. The WIC Branch of the Family Health Services Division administers the USDA FNS WIC program for the State of Hawaii.

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

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

With over 277 employees and an annual budget of nearly \$100 million, the Family Health Services Division is one of the largest divisions in the Hawaii State Department of Health (DOH). FHSD continues to focus on the four core operational issues identified through a strategic operations planning process in 2013:

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

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

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

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

The preparation for the 2017 Title V Review exemplified the innovations that typically emerge from the Title V Planning Committee. The Committee agreed the grant presentation in the previous year's Review was too lengthy and decided to create a short 5-minute video to present the Hawaii priorities using the Raw Shorts™ software. The video was well received at the Review and was shared with the MCH Bureau. The video was also highlighted in a 2018 AMCHP conference panel presentation on communications.

Based on best practice recommendations shared at the 2018 AMCHP skills-building sessions, FHSD decided to develop logic models to evaluate of the Title V strategies, activities for the national performance measures. Utilizing SSDI grant funds, FHSD contracted with the University of Hawaii Office of Public Health Studies faculty to provide technical assistance with this activity. The process of developing the logic models allowed staff to review program progress, identification of short- and long-term outcomes, and the alignment of strategies with Title V performance and outcome measures. Some changes were made to the plan strategies based on these discussions. The logic models are included in the 5-Year state plan narratives. The logic models may be tested next year as a tool to engage stakeholders and collect input on Title V activities.

FHSD also used a collaborative learning approach this year to complete the Title V budget/expenditure reporting with new fiscal staff. A fiscal team was convened to review and revise the budget/expenditure reporting method for the annual report. The team included Division level management and staff. Orientation on the Title V budget forms

and guidance was provided by the MCH Bureau. Regular consultation with branch and program staff helped to improve understanding of the Division's diverse funding sources, personnel ('What does she do?'), program purpose ('What do they do?'), levels of services ('What kinds of services do they provide?'), clients served ('who and how many people do they serve?'), and intended outcomes ('How does this service improve health?'). The process also improved overall understanding of the Title V budget, identified challenges posed by the fragmented administrative reporting systems, and developed greater appreciation for the critical safety-net/assurance role performed by the Division programs. Ongoing analysis of the Division resources will continue to help ensure all funding sources, including Title V, are used effectively to improve health outcomes.

Title V continues to utilize national MCH and AMCHP professional development resources including the MCH Workforce Development Center where Hawaii was part of the first cohort to receive intensive technical assistance (TA) on developmental screening. The use of process maps and continuous quality improvement were tools that the Hawaii team learned and shared with the rest of the Title V staff. Hawaii used TA from Johns Hopkins University Strengthening the Evidence efforts, MCH Bureau Learning labs, as well as recommendations from national consultants to select strategies and development strategy measures. 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.

In FY 2017, FHSD partnered with Hawaii MCH LEND to provide ongoing training for the Title V Leadership Committee as well as Division staff. Training topics provided included:

- Project Management
- Working Across Generations
- Mediation for Managers
- Meeting Facilitation Training
- Design for Behavior Change
- Effective Presentations: Introduction to PowerPoint and Graphic Design Basics.

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



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

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

In 2017, FHSD participated in the initial OSF cohort with DHS and subsequently sent participants to a third cohort in 2018. A second cohort was conducted for staff from the state Department of Human Resources. OSF is privately funded and utilizes resources donated by some of the states' largest corporations (Cohort Three sessions were held in the penthouse board room of one of the state's major banks) and is strongly endorsed by the current state Administration.

One of the Springboard projects from Cohort Three will bring OSF to FHSD in a customized format this Fall 2018. Funding has been secured for the training and planning for the specific modules has begun.

A project to design standardized program descriptions will be integrated into the OSF training as a springboard project. This project is intended to improve awareness and understanding of how FHSD programs serve Hawaii's families. The project is also designed to create a strong, more distinct identity for the Division to foster a greater sense of cohesion and inspire greater collaboration. A communications consultant has been retained as technical assistance for the project.

Another workforce development effort supported by FHSD is the Hawaii Public Health Training Hui (HPHTH) steering committee. The HPHTH is a group of individuals and organizations established to provide statewide leadership, coordination, and collaboration to meet identified common public health training and technical assistance needs.

To assess the current training needs of Hawaii's public health workforce, a survey tool was created and disseminated online to employees in both the public and private sectors. Survey findings led to the development of a training curriculum around the following four key areas: (1) community dimensions of practice; (2) health communication and informatics; (3) leadership and systems thinking; (4) and cultural competency. In August 2017, the HPHTH completed a total of 12 public health trainings.

FHSD continues to serve on the HPHTH steering committee and provides general oversight and direction for this training series. The committee meets quarterly for regular debriefing, and to identify topics and confirm speakers for the future training calendar.

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

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

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

- Genetics offers webinars on current issues in genetics to providers.
- The Child Abuse and Neglect (CAN) Prevention program conducts presentations on Protective Factors to prevent CAN.
- WIC staff have conducted 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

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

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

Family Engagement Workgroup

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

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

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

Thirty Title V programs that best reflects the FHSD and its branches, sections and units were selected to receive the survey (table below).

Family Health Services Division (FHSD)
1. Critical Access Hospitals (Flex)
2. Early Childhood Comprehensive Systems
3. Oral Health
4. Pregnancy Risk Assessment Monitoring System
5. Primary Care
6. Rural Health
7. Title V Maternal and Child Health
Maternal and Child Health Branch (MCHB)
8. Adolescent Wellness
9. CBCAP grant
10. Sexual Violence Prevention
11. Child Death Review
12. Domestic Violence/Fatality Review
13. Family Planning
14. Hawaii Home Visiting
15. Maternal Mortality Review
16. Perinatal Support Services
Children with Special Health Needs Branch (CSHNB)
17. Birth Defects
18. Childhood Lead Poisoning Prevention
19. Children and Youth with Special Health Needs
20. Early Childhood
21. Early Intervention
22. Genomics
23. Hi'iilei Hawaii Developmental Follow Along for Young Children
24. Newborn Hearing Screening
25. Newborn Metabolic Screening
Women, Infants and Children Branch (WIC)
26. Breastfeeding Peer Counseling
27. Women, Infants & Children (WIC)
FHSD Neighbor Island Offices
28. Kauai County
29. Maui County
30. Hawaii County

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

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

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

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

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

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

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

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

Findings: The top three engagement methods identified were ensure programs reflect diversity of the families being served, support family participation in local, state and national conferences, and use family input when planning,

creating and presenting of training materials. The bottom three engagement methods identified were family member as paid program staff, maintain family engagement policy, and designate an AMCHP family delegate for Hawaii.

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

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

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

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

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

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

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

In summary, family partnership engagement helps to ensure Division programs are effectively addressing the needs of those we serve. As next steps, FHSD will report findings to staff, begin developing a list of opportunities for family participation in Title V programs, and start identifying activities to improve and support family engagement moving forward.

Parent Leadership Training Institute (PLTI) Hawaii

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

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

A small group of dedicated PLTI Hawaii alumni continue to remain active and serve as mentors for future cohorts. The alumni group convenes in-person twice a year as well as communicates via social media. HCAN recently

provided opportunities for the alumni to utilize their new skills by participating on agency boards/commissions, and providing testimony on legislative bills. HCAN is working with FHSD to integrate graduates into Title V programs.

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

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

The primary purpose of State Systems Development Initiative (SSDI) grant is to develop, enhance, and expand state Title V MCH data capacity for its needs assessment and performance measure reporting in the Title V MCH Block Grant program. The key MCH datasets identified in the SSDI grant are used for surveillance, needs assessment, public education and awareness efforts, and evaluation across all 24 programs administered by Hawaii Title V. The table below shows dataset accessibility by Hawaii Title V programs.

Data Sources	State Has Consistent Annual Access to Data Source	State Has Direct Access to an Electronic Database	State Has Consistent Annual and Direct Electronic Access to Data Source	Describe Periodicity (if available more often than annually; does not need to be direct)	Indicate Lag Length for Most Timely Data Available in Number of Months	Data Source is Linked to Vital Records Birth
1. Vital Records Birth	Yes	No	No		9	
2. Vital Records Death	Yes	No	No		9	Yes
3. Medicaid	No	No	No		60	No
4. WIC	Yes	No	No		6	No
5. Newborn Bloodspot Screening	Yes	Yes	Yes	Quarterly	3	No
6. Newborn Hearing Screening	Yes	Yes	Yes	Quarterly	3	No
7. Hospital Discharge	No	No	No		60	No
8. PRAMS	Yes	Yes	Yes	Annual	24	

Hawaii uses its SSDI funds primarily to support the work of the Hawaii PRAMS program and previously used funds to support Hawaii State Department of Health participation in the infant mortality CollN that just ended in June 2017.

SSDI funding is critical to sustain PRAMS operations and staffing. The total annual costs of the Hawaii PRAMS Program (staff salaries, contracted services for data entry/cleaning, printing, postage, etc.) have increased significantly, while the Centers for Disease Control and Prevention (CDC) PRAMS funding has continued to decline. The most recent estimates indicate the current CDC PRAMS grant will cover only 60% of program salary and operations costs.

In the past, FHSD had access to de-identified birth and death certificate files to support Title V and other program and public requests for data. This access was limited in 2017 due to enforcement of a statute related to data sharing policies for the Hawaii vital records office. Access to complete data from the vital records office is limited, including data required for the annual Title V report. The ability we had to routinely link to other data sets such as WIC, newborn hearing, newborn metabolic screening was interrupted and currently on hold. There are ongoing discussions with

Department of Health leadership to address data sharing to support surveillance efforts across the Department. .

The restricted access to vital statistic data created significant challenges for the Hawaii PRAMS program which relies on birth records to draw its monthly sample. Efforts to rectify the situation included proposed legislative statute changes introduced in the 2018 legislative session. It is hoped the change in statute will restore access to data files for public health surveillance.

Other data challenges include the ending of the Hawaii Health Information Corporation and its ability to obtain and make available for purchase, data related to hospital emergency room and inpatient discharges. Until a new entity can make this data available, the Hawaii State Department of Health will not have access to this type of data.

There continues to be conversations about building an All Payers Claim Database (APCD) which would be limited to Medicaid, Medicare, and State Employee Union claims, but there is no current update on when the data will be available for analysis by researchers including the Department of Health.

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

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

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

The Title V agency's 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 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.

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

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

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

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

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



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

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

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

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

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

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

Current Agreements

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

Current Activities

- In 2017, MQD issued two provider memos supporting best practices promoted by the Hawaii Maternal and Infant Health Collaborative (HMIHC) and the DOH Strategic Plan. Memo # QI-1613 supports the One Key Question® (OKQ) screening approach, Long Acting Reversible Contraception (LARC), and expanded access to contraception. Memo QI-1612 supports prenatal Screening, Brief Intervention and Referral to Treatment (SBIRT) pilot project requiring training and reimbursements for participating obstetricians. MQD is now assisting with evaluation of the policies.
- FHSD requests to DHS/MQD for data for Title V annual report/application
- FHSD participates as a member of the EPSDT Advisory Committee.
- Working collaboratively with MQD to process reimbursements for telehealth including the teledentistry pilot.

Opportunities

- The Hawaii application for the Centers for Disease Control and Prevention Oral Health grant developed in conjunction with MQD includes several partnerships around data sharing, analysis, and service delivery.
- Medicaid payment for specialty formulas and medical foods. WIC is expected to be the payer of last resort for specialty formulas and medical foods. Depending on medical plan and diagnosis, DHS/MQD will pay for entirely tube-fed WIC clients and possibly oral feeding.
- Medicaid payment for childhood lead poisoning prevention activities such as follow-up of elevated blood lead levels. Two states are using Medicaid funding for the state childhood lead funding.
<http://www.astho.org/Programs/Environmental-Health/Built-and-Synthetic-Environment/Healthy-Communities/State-Stories--Medicaid-Reimbursement-for-Childhood-Lead-Poisoning-Services>. Texas has Medicaid reimbursement for childhood blood lead surveillance, data management, case coordination, provider and parent education and environmental lead investigation.
- Update old Title V - Title XIX agreement (1995).

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

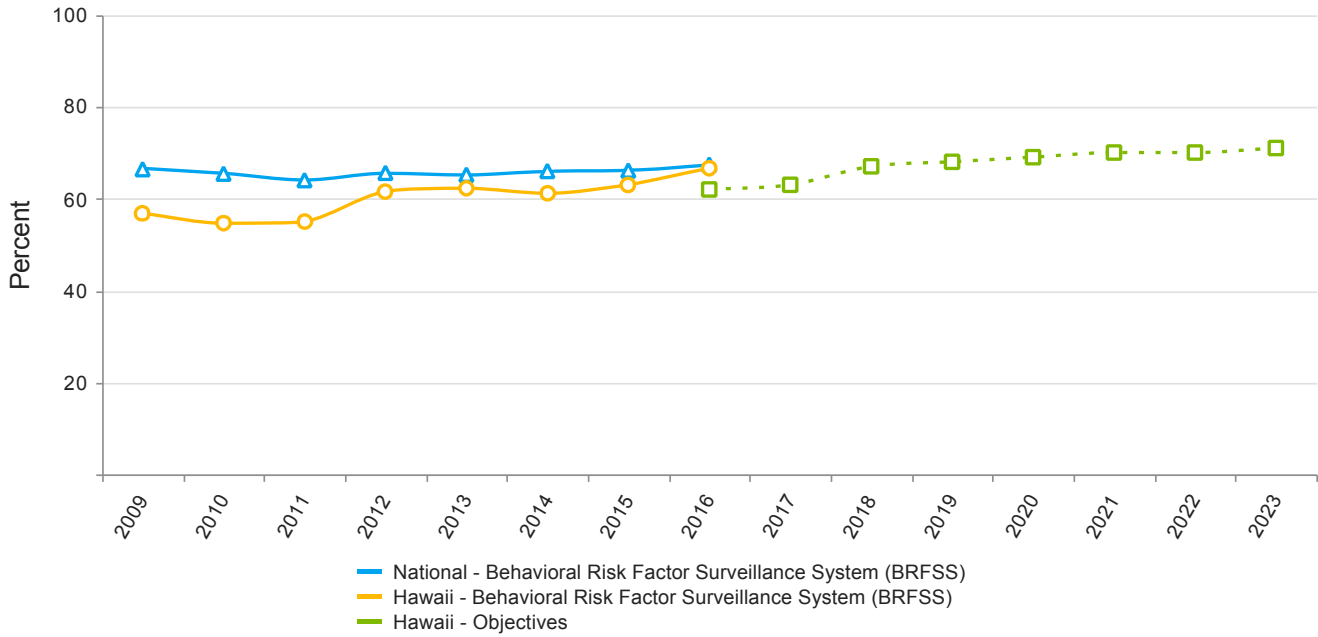
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	126.6	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2016	8.5 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2016	10.6 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2016	27.8 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2015	4.9	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	5.7	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2015	3.6	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	2.1	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2015	228.0	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2015	8.7 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2015	Not Reportable	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	19.2	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2015	9.0 %	NPM 1

National Performance Measures

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



Federally Available Data

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

	2016	2017
Annual Objective	62	63
Annual Indicator	63.0	66.7
Numerator	152,559	161,334
Denominator	242,088	241,941
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	67.0	68.0	69.0	70.0	70.0	71.0

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	31.0	31.0	30.0	30.0	30.0	30.0

State Action Plan Table

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

Priority Need

Promote reproductive life planning

NPM

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

Objectives

By July 2020, increase the percentage of women ages 18 through 44 who had a preventive medical visit in the past year to 65% (Baseline: 2013 Behavioral Risk Factor Surveillance System (BRFSS) data 62.3%)

Strategies

Promote women's wellness through systems building efforts

Promote pre/inter-conception health care visits

Promote reproductive life planning

ESMs

Status

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

Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

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

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

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

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

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Women/Maternal Health - Annual Report

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

Introduction: Preventive Medical Visit

For the Women/Maternal Health domain, Hawaii selected NPM 1 Well-Women visits based on the results of the 5-year needs assessment. By July 2020, the state seeks to increase the number of women who have a preventive medical visit to 65.0% this includes preconception and interconception care. In 2016, 66.7% of women in Hawaii received a preventive medical visit, which met the state objective. The rate was similar to the national estimate of 67.4%. There is no comparable Healthy People 2020 national objective.

This figure increased significantly since 2011 (55.0%). Subgroups analysis of 2014-2016 aggregated data showed disparities between race/ethnic groups: White (61.2%), Japanese (56.5%), and Other Pacific Islander (54.6%) are less likely to have a visit in the past year compared to Filipino (70.1%) women. It is unclear why Filipino women report such a high rate of preventive visits since normally this is considered a high-risk group for several health measures. Additionally, uninsured women (52.0%) are less likely to have had a visit in the past year compared to those with insurance (65.0%). There were no differences by age, household income, education level, employment, marital status, or county of residence.

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

Strategy: Promoting Women's Wellness Visits through Systems Building

Integrating Women's Wellness into State Health Plans and Initiatives

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

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

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

Hawaii Maternal and Infant Health Collaborative (HMIHC)

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

HMIHC was formed to sustain the plan and implementation activities. HMIHC completed a strategic plan, *The First 1,000 Days*, aimed at achieving the outcomes of 8% reduction in preterm births and 4% reduction in infant mortality

by 2020. To date, over 120 participants across Hawaii have been involved in HMIHC including physicians, clinicians, public health professionals, community service providers, insurance representatives and health care administrators.

Women's preventive health is viewed as a critical factor to reduce infant mortality, improve birth outcomes, and sustaining healthy families. HMIHC has a Pre- and Interconception Work Group focused on promoting optimal health before and between pregnancies in order to increase the number of births in Hawaii that are healthy and welcomed. The Work Group aims to reduce unintended and mistimed pregnancy by increasing clinical, educational and programmatic supports for pregnancy planning across the state.

HMIHC goals for preconception and interconception care are currently:

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

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

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

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

Early Childhood Action Strategies

Hawaii's Early Childhood Action Strategy initiative is a research-based, public-private collaborative comprised of over 100 professionals focused on supporting children's health, safety, development and learning.

<http://hawaiiactionstrategy.org/> Originally, launched under the former Governor's Executive Office on Early Learning the work is divided into 6 cross-disciplinary focus areas:

- Healthy and Welcomed Births
- Nurturing and Safe Families
- On-track Health and Development
- Equitable Access to Programs and Services
- Alignment and Transition Support Between Early Childhood Programs and into the K-3 System.

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

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

One of the three pillars of the DOH Strategic Plan 2015-2018 is a focus on Investing in Healthy Babies and Families. Women's reproductive health planning and health during pregnancy are an important focus in the plan. Strategies include promotion of the One Key Question® screening tool to decrease unplanned pregnancies and screening pregnant women for substance use to optimize the health of mothers' and assure healthy birth outcomes. The plan is

available on the DOH website: <https://health.hawaii.gov/opppd/files/2013/04/Hawaii-Department-of-Health-Strategic-Plan-2015-2018-081616.pdf>

State Early Childhood Strategic Plan

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

Strategy: Promote pre/interconception health care visits

One Key Question® (OKQ)

Hawaii adopted OKQ as an evidence informed intervention from the federal IM CollN. The One Key Question® screening protocol encourages providers to routinely ask women about their reproductive health needs to ensure pregnancies are wanted, planned, and healthy by asking "*Would you like to become pregnant in the next year?*" Developed by the Oregon Foundation for Reproductive Health (OFRH), OKQ assists women in identifying and clarifying their reproductive desires and goals, with a specific emphasis on promoting highly effective birth control methods for women who do not desire pregnancy. OKQ is also a method to address underlying maternal health conditions and risky health behaviors that may have a detrimental impact on both mother and baby's health before, during, and after pregnancy. This strategy focuses on a women's intent rather than what she plans since the concept of pregnancy planning does not always resonate with all ages, cultures, and backgrounds. OKQ developers advocate for screening in every healthcare encounter to address a woman's changing desires and goals. Regardless of the reason for a women's visit, the use of OKQ provides opportunities for a broad array of service providers to engage women in planning for their reproductive and general health needs.

In January 2016, HMIHC launched the One Key Question® initiative at its annual statewide meeting with keynote speaker Michele Stranger Hunter, Executive Director of the OFRH. Ms. Hunter also conducted OKQ training sessions for providers on implementation of the screening tool into their practices. OKQ was widely accepted at participating health care facilities and service programs forming a group of pilot sites for Hawaii implementation. Three Title V programs integrated OKQ into their service delivery: WIC, family planning, and the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). By December 2016, there were over 120 providers trained and 2,706 individuals reached with OKQ.

Policy. In November 2016, as a result of the partnership with HMIHC, the state Medicaid program released a provider memorandum, formally supporting the use of OKQ and expanded contraceptive coverage (including LARC). Medicaid Memo No. QI-1613 One Key Question and Contraceptive Coverage described the One Key Question® screening tool and counseling method, increased access to contraceptive care by eliminating prior authorization for Medicaid reimbursement, and allowed health plans to reimburse for dispensing up to 12 months of oral contraceptive supplies. The Memo can be found at <https://www.acog.org/-/media/Departments/LARC/HawaiiMedicaidLARCnotice20161110.pdf>

To increase access to contraception, the 2017 the legislature passed Act 067 which authorizes pharmacists to prescribe and dispense self-administered hormonal contraceptive supplies to patients, regardless of a previous prescription from an authorized prescriber. The law does require pharmacists to refer patients to their primary care provider upon prescribing and dispensing the contraceptive supplies. If the patient does not have a primary care provider, the pharmacist shall advise the patient to consult a licensed physician, advanced practice registered nurse,

or other primary care provider of the patient's choice.

Promotion. The 2017 annual HMIHC statewide conference presented OKQ implementation updates by the three Title V programs. Data collection efforts were also reviewed. Breakout sessions included OKQ. The Pre-Interconception Workgroup collected important stakeholder input that was used to update/revise the work plan and training. This included development of a locally-produced OKQ video by Ms. Hunter to promote the initiative and engage more providers. An initial 5,000 OKQ informational brochures were printed by the Title V agency Family Planning program and distributed to providers interested in the initiative.

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

OKQ trainings were hosted by HMIHC as well as integrated into the annual Home Visiting and Early Childhood Conferences. The Healthy Mothers Healthy Babies Coalition of Hawaii, through a March of Dimes Hawaii Chapter grant, completed eight statewide OKQ trainings for ten community health centers and other community partners. OKQ information was also provided through other public health initiatives including provider trainings sponsored by Title V programs: Zika: Prevention and Family Planning Care for Non-Pregnant Women and Men of Reproductive Age. By December 2017, a total of 339 providers were trained.

The trainings have evolved based on the experience and feedback from OKQ providers. Additionally, many non-clinical providers requested further training/information on contraceptive options, referral resources, and assistance to address challenging situations including working with adolescents.

The One Key Question[®] training curriculum was expanded to include an overview of reproductive life planning and contraception, dealing with challenging client scenarios, and community resources. Participants are now given the knowledge required to effectively and sensitively introduce the concept of family planning, birth spacing, and setting family planning goals, information to dispel common myths about pregnancy and safe sex (a substantial problem among adolescents), and ways to create a client-centered focus that allows for ambivalence, uncertainty, and individualized approaches. A OKQ comprehensive information packet was developed and integrated into OKQ trainings to assist providers. The Title V Family Planning program assisted with packet development, printing and distribution.

The September 2017 Hawaii Journal of Medicine & Public Health published an article on insights learned from the One Key Question[®] campaign written by HMIHC members including MIECHV staff. <https://www.hjmph.org/76.09.htm>

The topics of pregnancy planning and birth spacing have been discussed at all three Maternal Morality Reviews conducted during 2017 and 2018 One Key Question[®] screening was included in recommendations as a potential tool to prevent adverse maternal outcomes.

Messaging: SafeSex808

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

Long Acting Reversible Contraception (LARC)

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

HMIHC's Pre-Interconception Work Group activities focused on clarifying policies for LARC insurance reimbursement: 1) immediately postpartum prior to hospital discharge, and 2) for outpatient visits for women of reproductive age. HMIHC developed two white papers on LARC 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.

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

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

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

Other activities.

In FY2017, the DOH Title X Family Planning Services program, administered by the Title V agency, provided () comprehensive statewide family planning services to 16,002 clients in 24,435 visits. Services include client-centered education and counseling, pregnancy testing and counseling, basic infertility services, preconception health, sexually transmitted disease 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 client centered education and counseling.

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

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

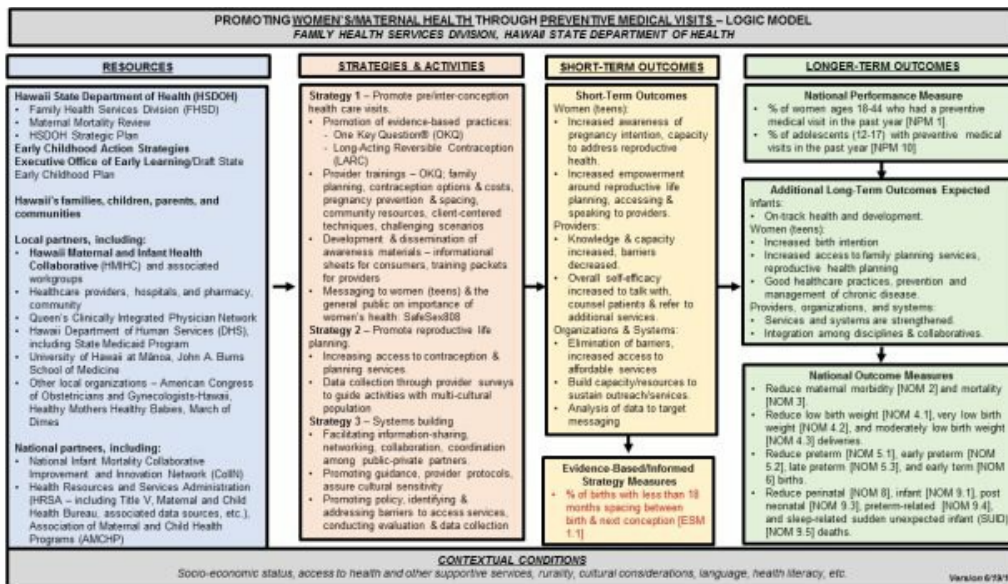
The Evidence Based/Informed Strategy Measure (ESM) selected for women's preventive medical visits is the percent of births with less than 18 months spacing out of total births. The measure is related to one of HIMHC goals for preconception and interconception care (women's preventive health) to improve birth spacing through reproductive life planning education and counseling. The FFY 2017 indicator is 31.8% of births met the recommended birth spacing criteria. The data is provisional. The 2017 objective (34%) was not met.

Review of the Action Plan

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

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

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



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

Challenges, Barriers

Some of the ongoing challenges to implementing activities include:

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

Overall Impact

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

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

Additionally, Title V used the resources of key partners to provide leadership, staffing and funding to sustain these collaborative efforts over the past four years. These resources are crucial since the MCH Branch recently

experienced significant staff turnover/retirements and funding cuts. An example of the collaborative efforts include the funding for the state Coordinator for the HMIHC through the Preventive Health and Health Services Block Grant (PHHSBG), administered by the DOH Office of Planning, Policy and Program Development. The grant funding is critical to sustaining the momentum and work of the HMIHC and supported OKQ and LARC activities as well as workforce training.

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

The Title V Women's Health Section Supervisor, who also co-chaired the Pre-Interconception Work Group, is currently vacant due to retirement. Efforts are underway to recruit and hire for this critical position by the of summer.

Women/Maternal Health - Application Year

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

For the Women/Maternal Health domain, Hawaii selected NPM 1 Well-Women visit based on the results of the 5-year needs assessment. By July 2020, the state seeks to increase the number of women who have a preventive medical visit to 65.0% this includes preconception and interconception care. Plans to address this objective and NPM are discussed below.

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

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

Based on the success of trainings, both clinical and non-clinical OKQ provider trainings will continue. Discussions with the DOH, FHSD, Genomics Section to implement OKQ trainings through telehealth are in progress. The ESM for NPM 1 will likely be revised based on the streamlined activities of the HMIHC Pre-Interconception Work Group.

HMIHC, CoIN, 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.

Title V Women's Health Programs

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

Women Infants and Children (WIC): The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a federally funded program that provides Hawaii residents with nourishing supplemental foods, nutrition education, breastfeeding promotion and health and social service referrals. The participants of WIC are either pregnant, breastfeeding, or postpartum women, and infants and children under age five who meet income guidelines and have a medical or nutritional risk.

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

Family Planning Services: assists individuals in determining the number and spacing of their children and

promotes positive birth outcomes and healthy families. Education, counseling and medical services available through federal and state funded clinical programs. The program provides leadership for the implementation of One Key Question® (OKQ) – “would you like to become pregnant in the next year?” OKQ supports reproductive life planning, decreases unplanned pregnancies, and promotes healthy birth outcomes.

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

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

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

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

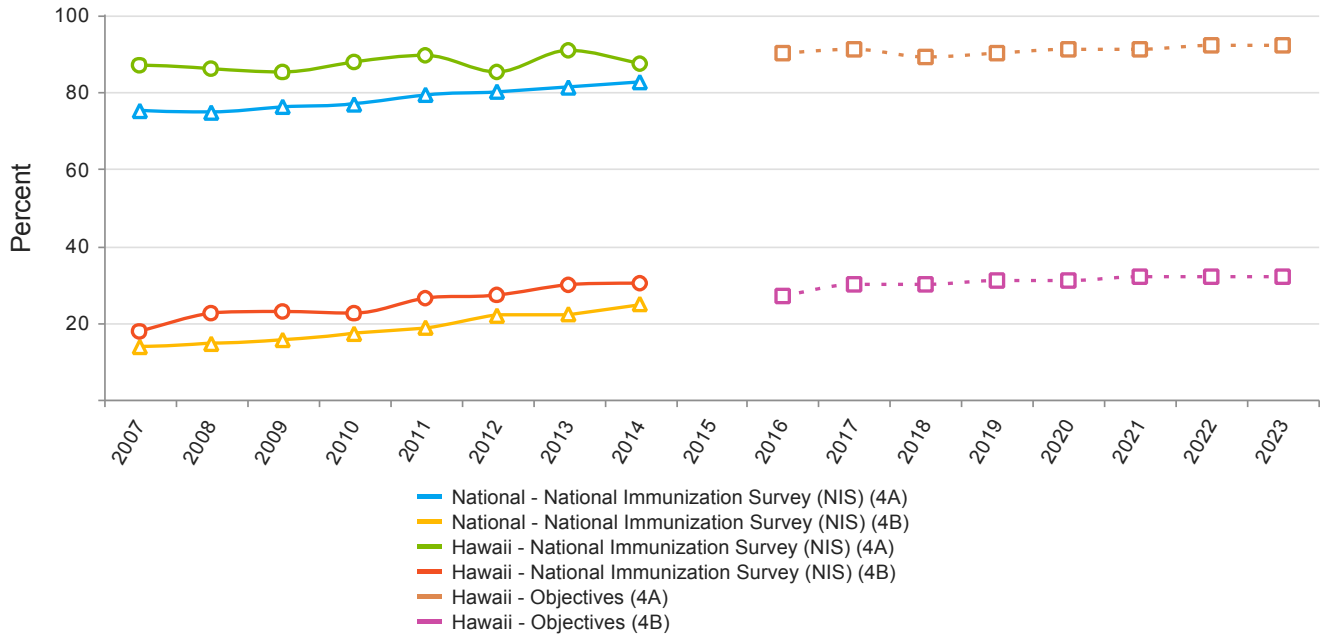
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	5.7	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	2.1	NPM 4 NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	76.0	NPM 4 NPM 5

National Performance Measures

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



NPM 4A - Percent of infants who are ever breastfed

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	89.0	90.0	91.0	91.0	92.0	92.0

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

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	30.0	31.0	31.0	32.0	32.0	32.0

Evidence-Based or –Informed Strategy Measures

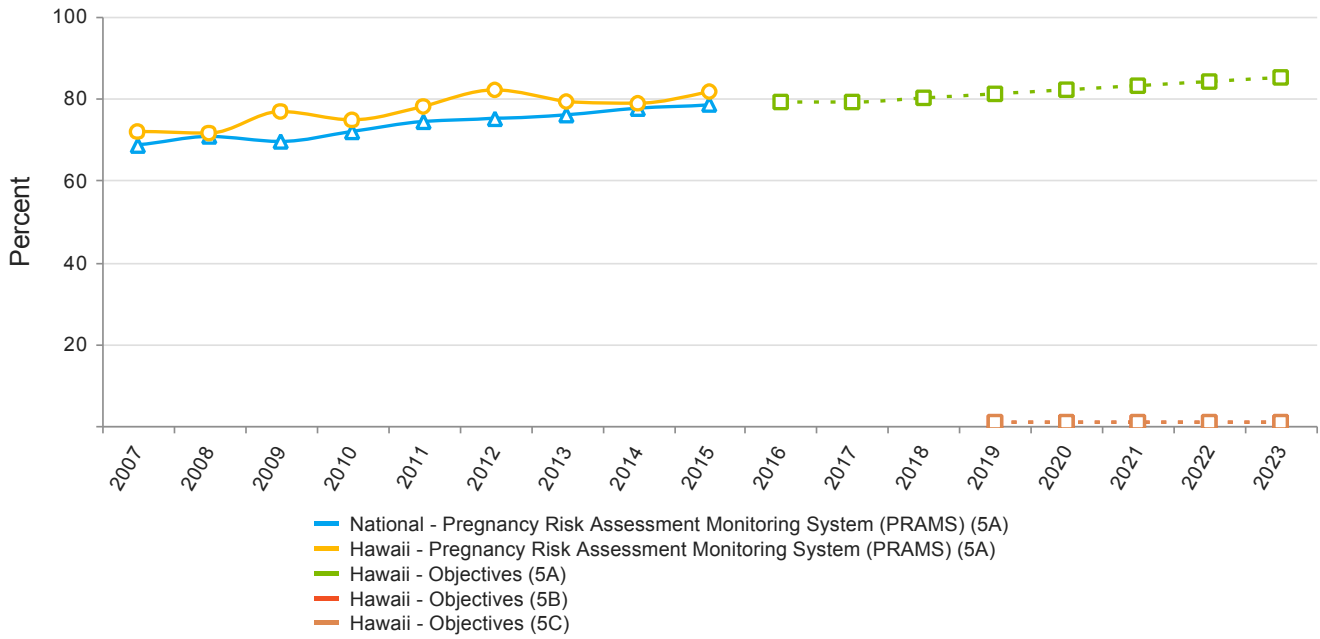
ESM 4.1 - Percent of Women, Infants, and Children (WIC) infants ever breastfed

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	81.0	82.0	83.0	84.0	85.0	85.0

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



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

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	80.0	81.0	82.0	83.0	84.0	85.0

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

FAD for this measure is not available for the State.

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

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

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

FAD for this measure is not available for the State.

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

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

Evidence-Based or –Informed Strategy Measures

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

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	100.0	100.0	100.0	100.0	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

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

Objectives

By July 2020, increase the percent of infants who are ever breastfed to 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

Partner with community-based organizations to promote and support breastfeeding

Promote collaboration and networking

ESMs

Status

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

Active

NOMs

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

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

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

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

Priority Need

Reduce the rate of infant mortality

NPM

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

Objectives

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

Strategies

Policy Development: Implementation of safe sleep policies

Assure competent workforce

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

ESMs

Status

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

Perinatal/Infant Health - Annual Report

For the Perinatal/Infant Health domain, Hawaii selected two performance measures:

- NPM 4 (A & B) Breastfeeding
- NPM 5 (A, B, C) Safe Sleep

Reports on progress for the two measures are described below.

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

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

Introduction: Breastfeeding

Healthy People 2020 establishes breastfeeding initiation, duration, and degree of exclusivity as nationally recognized benchmarks for measuring success. For the Perinatal/Infant Health domain, Hawaii selected NPM 4 (breastfeeding) based on the results of the Title V needs assessment. The first component of the 2020 Title V state objective is to increase the proportion of children who are ever breastfed to 94.0%. The 2017 indicator is from the 2014 National Immunization Survey (latest available data). The estimate for Hawaii (87.3%) failed to meet the annual objective, but was similar to the national estimate of 82.5%. The current estimate for Hawaii has not changed significantly since 2009 (84.9%). There were also no significant differences among reported subgroups (birth order, educational attainment, household income, poverty level, marital status, maternal age, and race/ethnicity) based on the 2009-2011 aggregated data provided.

For the second component of the breastfeeding NPM, the 2020 Title V state objective is to increase the proportion of children who are breastfed exclusively through six months to 28.0%. In 2014 (the latest available data), the estimate for Hawaii (31.0%) surpassed the objective, as well as the national estimate of 24.9%. The proportion of Hawaii children breastfed exclusively through six months has increased since 2007 (from 18.0%). Higher risk groups were not assessed due to lack of federally available data.

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

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

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

- Hawaii Rev. Stat. § 367-3 (1999) requires the Hawaii Civil Rights Commission to collect, assemble and publish data concerning instances of discrimination involving breastfeeding or expressing breast milk in the workplace. The law prohibits employers to forbid an employee from expressing breast milk during any meal period or other break period.
- Hawaii Rev. Stat. § 378-2 (2000, Act 227) provides that it is unlawful discriminatory practice for any employer

or labor organization to refuse to hire or employ, bar or discharge from employment, withhold pay from, demote or penalize a lactating employee because an employee breastfeeds or expresses milk at the workplace.

- Hawaii Rev. Stat. § 489.21 and § 489-22 provide that it is a discriminatory practice to deny, or attempt to deny, the full and equal enjoyment of the goods, services, facilities, privileges, advantages, and accommodation of a place of public accommodations to a woman because she is breastfeeding a child. The law allows a private cause of action for any person who is injured by a discriminatory practice under this act.
- Hawaii Sess. Laws. (2013, Act 249) requires specified employers to provide reasonable break time for an employee to express milk for a nursing child in a location, other than a bathroom, that is sanitary, shielded from view and free from intrusion. The law also requires employers to post notice of the application of this law in a conspicuous place accessible to employees.
- 2016 Session (Act 46) exempts from jury duty a woman who is breastfeeding or expressing breast milk for a period of two years from the birth of the child.

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

The Hawaii Title V breastfeeding strategies were derived from the *Actions for Communities* section of the 2011 Surgeon General's *Call to Action to Support Breastfeeding* and are generally accepted by Hawaii breastfeeding stakeholders including Breastfeeding Hawaii, the Early Childhood Action Strategy (ECAS) office, the HMIHC, the Perinatal Action Network, Healthy Mothers Healthy Babies, and the March of Dimes.

Strategies to address the objectives and NPMs are discussed below.

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

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

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

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

Feedback collected from WIC mothers indicates a high level of satisfaction with the program, particularly the camaraderie shared in the group meetings which is the primary aim of the program (i.e., to provide mothers with a trusted friend who has breastfed). Peer Counselors become part of a mother's "Circle of Care," providing basic

breastfeeding information, monthly contacts during the pregnancy and postpartum period, and referrals to designated resources when issues fall beyond their scope of practice. The program is currently located at four WIC offices at community based organizations, as well as three state-run WIC offices. A total of four peer counselors currently service all seven sites. The program is located only on Oahu.

Funding for the BFPC Program comes from USDA and is managed by the WIC Services Branch. Each local office recruits peer counselors and must follow the protocols as outlined in the *Loving Support*® model. Recruitment and retention of peer counselors can be challenging since the positions are part-time and applicants are normally seeking full-time employment.

To ensure quality support services, maintaining overall staff competency around breastfeeding and infant feeding issues is paramount. In 2017, WIC staff attended Certified Lactation Counselor trainings provided by the Healthy Children Project, and Baby Behavior training provided by Dr. Jane Heinig, Executive Director of the UC Davis Human Lactation Center. The Baby Behavior training also included hospital staff from nine birthing hospitals in the State, allowing WIC staff to network with the hospital lactation staff.

To reinforce breastfeeding promotion (and other important health messages), WIC staff refer clients to the Healthy Mothers Healthy Babies “Text4Baby” service. The service sends enrollees free text messages on prenatal care, baby health, breastfeeding and parenting tips throughout pregnancy and baby’s first year of life.

ESM 4.1 is the measure for this strategy: the percent of WIC infants ever breastfed. The numerator is calculated using the number of unduplicated WIC infants who were marked as currently breastfeeding (or if not currently breastfeeding, marked as having previously breastfed). The denominator is the sum of all unduplicated WIC infants.

FY 2017 data is unavailable while WIC transitions to a new management information system. Data will be available for FFY 2017 in next year’s report. Thus, the FY 2016 ESM indicator of 80.6% is carried forward. The data were collected over the state fiscal year ending June 30, 2016.

Strategy 2: Partner with community-based organizations to promote and support breastfeeding.

WIC partners with community based organizations to promote and support breastfeeding. Over the past 15 years, WIC has gradually transitioned its service provision from stand-alone state-operated clinics to contracting WIC services with community based organizations like the Federal Qualified Health Centers. These organizations specialize in providing an array of services to low-income and underserved populations, hire staff that often reflect the diverse cultural groups found in these communities, and have access to language translation resources. Thus, WIC offices located in these organizations may be more effective in reaching WIC clients and providing services, including breastfeeding support.

WIC also works in conjunction with other Title V programs serving high-risk pregnant women by offering breastfeeding education and training to staff, service contractors, and community partners. These programs include the Maternal and Child Health Branch’s state-funded Perinatal Support Services program, the Hawaii Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, and the associated MIECHV Hawaii Home Visiting Network.

Strategy 3: Collaboration and networking.

Engaging key partners – Hawaii has an active state breastfeeding coalition, Breastfeeding Hawaii (BH), that works

to promote, protect and support breastfeeding through collaboration of community efforts around outreach, legislation, policy enforcement, education, and advocacy. The state WIC breastfeeding coordinator is a board member of BH, and also serves as a liaison to CDC's Division of Nutrition, Physical Activity and Obesity and the United States Breastfeeding Coalition.

As noted earlier, efforts to improve breastfeeding rates are championed by two important state maternal and child health entities: the Hawaii Maternal and Infant Health Collaborative (HMIHC) and the Early Childhood Action Strategy (ECAS). In 2017, HMIHC and ECAS convened key organizations to develop a state breastfeeding plan. In addition to FHSD WIC staff, the Title V Early Childhood Comprehensive Systems (ECCS) coordinator has provided critical leadership support to the process, including integration of breastfeeding into EC state systems planning and services where appropriate.

Other participants of the state planning efforts included: Breastfeeding Hawaii, Healthy Mothers Healthy Babies, March of Dimes, University of Hawaii Office of Public Health Studies, University of Hawaii School of Nursing and Dental Hygiene, University of Hawaii John A. Burns School of Medicine, American Academy of Pediatrics – Hawaii Chapter, Kona Community Hospital, Hawaii Public Health Institute, Early Head Start and Head Start, Family Support Hawaii, BAYADA Home Care, La Leche League, Hawaii Mothers Milk, Family Hui Hawaii, several Federally Qualified Health Centers, and Tripler Army Medical Center.

Advocacy/statewide coordination – The Breastfeeding State Plan and its Logic Model focuses on four strategic areas: (1) leadership, (2) messaging & training, (3) laws & policies, and (4) support for families needed at critical junctures during the prenatal/postpartum period. Although there are no funds to implement the Plan, it serves as a guide to align existing breastfeeding efforts conducted by individual organizations and agencies. Without dedicated staffing, it will be challenging to monitor and support plan progress. ECAS has committed to convene breastfeeding partners annually to report activity updates and review plans for the upcoming year. This model of short-term action planning and reporting is quite effective for other HMIHC work groups (e.g., see NPM 1 on women's wellness).

To finalize the state plan, HMIHC Infant Health & Safety Team held a technical assistance meeting with Diane Spatz, PhD, RN-BC, FAAN, to solicit feedback on the Breastfeeding Logic Model and Action Plan. Professor Spatz is a faculty member at the University of Pennsylvania and is recognized for many achievements in lactation support and care. This includes 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.

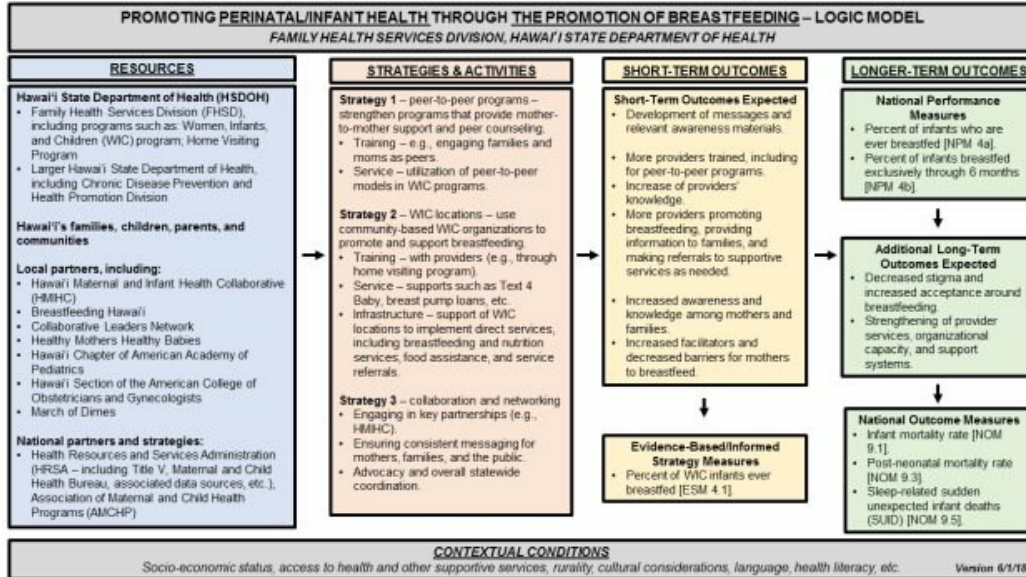
Consistent messaging – To develop consistent breastfeeding messaging and utilize best practices, Breastfeeding Hawaii hosted a 3-hour skill-building workshop titled "Helping Families Succeed at Breastfeeding." The workshop was marketed to parents, healthcare providers, birth and lactation support providers, social workers, and students in these fields.

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

Finally, a leadership development training titled *Daring Greatly to Remove Barriers to Breastfeeding* was provided to the same cohort that attended the *Secrets of Baby Behavior* workshop. These were sponsored by the DOH Chronic Disease Prevention and Health Promotion Division as part of their ongoing Baby-Friendly Hospital Initiative.

Review of Action Plan

A logic model was developed for NPM 4 to review the alignment between the strategies, activities, measures and desired outcomes. By working on these strategies, the Hawaii Title V program plans to meet the breastfeeding objectives for ESM 4.1 and NPM 4 to increase the percentage of infants breastfed.



The common thread through all three strategies is to increase the points of contact within a mother's circle-of-care. To differentiate between strategies which focus on direct service delivery to mothers and families, versus larger systems development and improvement (i.e., policy, environment), a third strategy was added to the 5-year plan for breastfeeding. Systems work will be critical to assure measured progress for the NPM.

Challenges Encountered

WIC enrollments are decreasing nationally and in Hawaii. Due to decreasing WIC caseloads, the WIC Breastfeeding/Outreach Coordinator position was eliminated in 2017 as part of a reduction-in-force action. 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. Duties are reassigned to existing staff, but reduce the level of breastfeeding support provided to WIC offices statewide. WIC mothers may not enjoy the same level of support and follow-up provided in previous years and the monthly group meeting conducted through the BFPC program may no longer be sustainable given the staffing cuts.

Recruitment and retention of staff for the BFPC program also continues to be a challenge. Reasons for peer counselors leaving the program have varied, including returning to school, deciding to stay home with new baby, need for higher salary, and moving out-of-state.

Despite Hawaii's excellent breastfeeding initiation rate, the CDC's Maternity Practices in Infant Nutrition and Care report shows that birthing facilities in Hawaii still have opportunities for improvement. The report is based on a survey of hospital practices conducted every two years. Areas for improvement include appropriate use of breastfeeding supplements, inclusion of model breastfeeding policy elements, provision of hospital discharge planning support,

and adequate assessment of staff competency. Since the benefits of breastfeeding are dose-related, duration and degree of exclusivity need to be reviewed as well.

Hawaii WIC data show that among mothers who stop breastfeeding in the infant's first year of life, the majority stopped between the first 2-4 weeks after hospital initiation. The primary reason mothers cite is not having enough milk. Additional data collection is needed to determine if moms' responses are due to true milk insufficiency or formula supplementation. Such information would greatly inform the breastfeeding support offered by the BFPC, which could be critical to ensuring mothers' continuation of the practice.

Overall Impact

The FHSD WIC Services Branch breastfeeding promotion program can access a large high-risk population of pregnant women and young mothers to help promote and support breastfeeding in Hawaii. The Hawaii WIC program services nearly half the births in the state. Despite loss of staffing, WIC state offices and community contractors continue to promote breastfeeding to clients, as well as provide training/resources to WIC contractors and other community organizations servicing pregnant women and new mothers.

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

Additionally, Title V leveraged resources of key partners to provide leadership, staffing, and funding to sustain community based activities beyond WIC. For example, the coordinator for the Hawaii Maternal Infant Health Collaborative helped to convene breastfeeding stakeholders, coordinate statewide planning, and access national technical assistance resources. The Early Childhood Action Strategy also continues to promote breastfeeding and is participating in the HMIHC Breastfeeding Strategic Planning process. The Strategic Plan will be key in seeking resources for breastfeeding efforts such as reinstating a State Breastfeeding Coordinator position.

Other Title V programs serving high-risk pregnant women also offer an opportunity to promote breastfeeding through education, workforce training, and support services. Partner programs include the MCH Branch Perinatal Support Services program and the Hawaii Home Visiting Network, supported by the Hawaii Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant. In addition, the Title V Early Childhood Comprehensive Systems (ECCS) coordinator ensures breastfeeding is integrated into state systems planning and services where appropriate. Finally, breastfeeding promotion is included in the Executive Office on Early Learning (EOEL) Early Childhood Strategic plan for the state.

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

Introduction: Safe Sleep

For the Perinatal/Infant Health domain, Hawaii selected NPM 5 Safe Sleep based on the results of the Title V needs assessment. The 2020 Title V state objective is to increase the proportion of infants placed to sleep on their backs to 83.0%. Data from 2015 showed that Hawaii nearly met that objective (81.5%), but exceeded the national estimate of 75.8%. The proportion of infants placed to sleep on their backs has increased significantly since 2007 (71.7%). Analysis of Hawaii PRAMS 2012-2015 aggregated data revealed Native Hawaiian (72.9%) were less likely to place their infants on their back compared to Filipino (82.5%), White (86.3%), Chinese (87.6%), and Japanese (89.0%)

mothers. Mothers that were under 20 years of age (70.0%) and 20-24 years of age (75.5%) were less likely to place their infants on their back to sleep compared to mothers that were 25-34 (82.3%) and 35 or more years (82.4%). Mothers who were on Medicaid/QUEST during prenatal care (76.2%) were less likely to place their infants on their back to sleep (76.2%) compared to mothers on private/military (82.4%) insurance.

In the new Title V guidance, two additional safe sleep measures were added to determine whether infants are placed on an approved sleeping surface and place with soft objects or loose bedding that may endanger infant safety. Data for these two measures are not available now.

The Title V needs assessment confirmed the importance of providing safe sleep education and training to parents and childcare providers as a priority issue. The Hawaii Maternal and Infant Health Collaborative (HMIHC) and Early Childhood Action Strategy (ECAS) identified promotion of safe sleep practices as an important priority to improve birth outcomes and reduce infant mortality. HMIHC identified two priority strategies to achieve the objective of decreasing infant mortality in the first year of life: 1) foster safe sleep practices for all who care for infants and 2) provide professional development and training opportunities for caregivers of infants.

Although safe sleep is part of the Title V Maternal and Child Health Branch (MCHB) program efforts, implementation of the strategies is a collaboration across the Family Health Services Division (FHSD). MCHB provides general support and leadership for the Safe Sleep Hawaii Program (SSHP) and the SSH Coalition (SSHC) which is a statewide partnership that promotes life-saving safe sleep techniques, policies and education for parents, teachers, health professionals, and other caregivers. The CSHN Branch nurse manager for the Newborn Metabolic Screening program integrated safe sleep into the work of the existing Perinatal Nurse Managers Task Force (PNMTF) which represents all the birthing hospitals. There is no dedicated funding source for Safe Sleep staffing or program activities; however, Title V funded staff help to support overall Safe Sleep efforts.

Strategies to address the objectives and NPMs are discussed below.

Strategy 1: Policy Development. Implementation of safe sleep policies at birthing hospitals and child care centers and providers.

This strategy focuses on identifying, reviewing, and monitoring birthing hospitals safe sleep policies, protocols, or guidelines. The state PNMTF is critical to implementing this strategy. The CSHN Branch nurse convenes the PHNTF and membership includes at least one perinatal nurse manager from each of Hawaii's twelve birthing hospitals. Meetings are held quarterly via teleconference; in person annually; and ad-hoc teleconferences as needed. The main focus of the PHNTF is policy development and promotion of the most recent version of the AAP evidence base recommendations for a Safe Infant Sleeping Environment at birthing hospitals, child care centers, and child care providers. More specifically, the PNMTF works to identify, obtain, review, and monitor birthing hospitals safe sleep policies, protocols, or guidelines; and, assure compliance with the most recent AAP safe sleep guidelines. Implementation of SS policies and practices at all birthing hospitals help assure high-risk families are exposed to SS messaging.

The ESM 5.1 for this strategy is the "Percent of birthing hospitals with current American Academy of Pediatrics safe sleep protocols." PHMTF collects and reports the data for this measure. The objectives for the ESM were set in partnership with SSHP. The FFY 2017 indicator for ESM 5.1 is 92%. Only one hospital did not complete implementation by the end of FY 2017. Table 1 lists the birthing hospitals in Hawaii by county and the dates Safe Sleep policies were implemented and reviewed.

Table 1: Birthing Hospitals in Hawaii-Safe Sleep Environment Policy Summary

Facility Name	County	Date Policies Implemented/Reviewed
Castle Medical Center	Honolulu	01/31/2017
Hilo Hospital	Hawaii	11/17/2016
Kaiser Permanente	Honolulu	9/18/2007, Reviewed 9/18/2010
Kapiolani Medical Center for Women and Children	Honolulu	11/2007, reviewed 12/19/2014 (previous versions 9/12/1997, 7/12/2002, 7/8/2005, 11/10/2006
Kauai Veteran's Memorial Hospital	Kauai	11/01/2016
Kona Community Hospital	Hawaii	7/1/2016
Maui Memorial Medical Center	Maui	02/2017
Molokai General Hospital	Maui	9/13/2016
North Hawaii Community Hospital	Hawaii	10/12/2017
Queens Medical Center	Honolulu	06/2016
Tripler Medical Center	Honolulu	3/29/2007, reviewed 9/2001, 11/2002, 11/2007, 12/2009, 6/2012
Wilcox Medical Center	Kauai	04/2016, reviewed 09/2001, 11/2002, 11/2007, 12/2009, 6/2012

The table captures work through FY 2018 and indicates the ESM will be fully achieved in next year's Title V report.

Strategy 2: Assure Competent Workforce.

This strategy focuses on identifying safe sleep competency training needs for birthing hospital professionals. The PNMTF continues to focus on assuring a competent workforce and recognizes the need to provide training opportunities for new nurses and keeping regular staff trained on the most recent safe sleep environment recommendations. Birthing hospitals do not have safe sleep environment as a competency. However, it is discussed at discharge and included on the discharge check list. Hospitals utilize various means to promote safe sleep education including discussions at staff meetings, creation of a safe sleep committee, and inclusion at a staff skills fair. A standing agenda topic is the need for consistent teaching, messaging and encouraging staff to access the safe sleep trainings for nurses on the National Institute of Child Health and Human Development website. The CSHNB nurse on the PNMTF serves as the Safe Sleep subject matter expert and provides technical assistance and training on safe sleep environment policy, protocol development and guidance on related issues.

Strategy 3: Inform, Educate, Empower. Develop appropriate and consistent parental education and general awareness safe sleep messages.

This strategy focuses on identifying decision-makers, key partners, and resources to develop safe sleep messages for parents and others who care for infants. The Safe Sleep Hawaii Program (SSHP) Coordinator of the MCHB is responsible for managing the deliverables of the SSHC Facilitator Contract, coordinating the efforts relating to safe sleep within MCHB, and acts as "point person" for all safe sleep related inquiries and activities. The contract is state funded. Services are contracted with a Registered Nurse Facilitator who convenes a quarterly meeting of the SSHC; identifying relevant safe sleep materials and opportunities; maintaining the SSHC membership and list serve; convening the sub-committee on identifying AAP approved on-line training courses for caregivers at child care

facilities; providing ad-hoc safe sleep advice, and coordinating a yearly Safe Sleep Summit. The Nurse Facilitator is also contracted by the DOH Injury Prevention Program (which is not under Title V) to coordinate the State Child Injury Prevention Coalition (Keiki Caucus), thus integrating SS into overall child injury prevention efforts.

The SSHC focuses on developing appropriate and consistent parental education and general awareness of safe sleep practices in adherence to the most current version of the *AAP Evidence Base Recommendations for a Safe Infant Sleeping Environment at birthing hospitals, child care centers, and child care providers*.

A diverse group of representatives make up the SSHC’s membership (Table 2 below) with representation from government and non-profit sectors, for-profit sectors, grass-roots organizations and representatives from families who have a commitment to preventing infant mortality through safe sleep practices. In-person SSHC meetings are held quarterly and ad-hoc teleconferences scheduled as needed.

Table 2: Safe Sleep Hawaii Coalition Membership

ORGANIZATION	COUNTY
Castle Medical Center	Honolulu
Child and Family Services	Statewide
Department of Health - Maternal Child Health	Statewide
Department of Health-FHSD	Statewide
Department of Health-FHSD-Public Health Nursing	Statewide
Department of Human Services	Statewide
Hawaii AAP	Statewide
Hawaii Primary Care Association	Statewide
Health Mothers Healthy Babies	Statewide
Kaiser Permanente	Statewide
Kapiolani Hospital for Women and Children	Honolulu
Keiki Injury Prevention Coalition	Statewide
March of Dimes	Statewide
Military (Navy)	Statewide
PATCH (People Attentive to Children)	Statewide
Private Citizens	Honolulu
Queens Medical Center	Honolulu
Shriners Hospital for Children	Statewide
Waianae Coast Comprehensive Health Center	Honolulu
Wilcox Medical Center	Kauai

SSHP and SSHC Activities:

Data to inform Program Planning/Policy

To encourage use of data to inform program planning, an FHSD Infant Safe Sleep Fact Sheet was developed using data from PRAMS and the Child Death Review (CDR) program. This fact sheet provides general information on Sudden Unexpected Infant Deaths (SUID) and SIDs; data trends; highlights the importance of creating a safe sleep environment. This fact sheet is accessible via the HI-PRAMS website @ <http://health.hawaii.gov/fhsd/home/hawaii-pregnancy-risk-assessment-monitoring-system-prams/>. This fact sheet was shared with key-stakeholders, PRAMS steering committee members, the SSHC, and with the CDR program. Plans are to develop new and update existing fact sheets relating to safe sleep; and propose studies on co-sleeping in relation to substance use/abuse.

Parent/Family Educational Tools

Currently the SSHP offers an 8.5" x 11" glossy *Keep Me Safe While I Sleep* poster in four different languages: English, Chuukese, Marshallese and Spanish. Posters are distributed to parents at birthing hospitals, community health centers, through the Maternal and Child Health Branch's Home Visiting Program, and at the Department of Human Service's First to Work Program.



Safe Sleep Guide for Parents

In a partnership with the Department of Human Services (DHS), the SSHP is working on a new guide for parents and caregivers. This new guide includes AAP recommended guidelines regarding safe sleep environments, a letter from a family "Don't let a preventable infant death happen...", and unfolds into a poster that can be displayed in the infant's home, in pediatrician offices, and or used as a training tool. To create a "parent friendly" guide, families were engaged to provide input for message development and promotion of safe sleep materials via a survey. The survey was administered at DHS's First to Work Program and the Community Children's Council. The guide will be distributed by programs such as Women, Infants and Children (WIC), MCH's Child Abuse and Neglect Prevention and Home Visiting Programs, Child and Family Services, Community Health Centers, at the twelve birthing hospitals throughout the state, and with any crib distribution program sponsored by MCHB.

Promotion of Safe Sleep Environments

The nurse educators who conduct child birth classes at birthing hospitals provide education to parents about safe sleep environments. Two hospitals have a safe sleep poster in each of their birthing rooms that stress the importance of providing a safe sleep environment for infants. Nurses have expressed how useful it is to have a poster to refer to when teaching family members about safe sleep.

A copy of the Safe Sleep Hawaii video is available for birthing hospitals to play on their internal video site @ <http://www.safesleephawaii.org/>. The largest maternity hospital in the state requires parents to view the Safe Sleep Hawaii Video prior to discharge.

Licensed Child Care Facilities

The Department of Human Services (DHS) is responsible for the licensing of child care facilities statewide. The Hawaii Administrative Rules §346-152.7 Safe Sleep Policy and HAR §17-891.1-41 and §17-895-45 Program Requirement was amended in 2017 to require all child care facilities to have a written operational policy regarding safe sleep and all caregivers must review those policies and undergo an annual Department of Human Services (DHS) approved training on safe sleep practices.

DHS consulted with the PNMTF and the SSHC to identify AAP approved on-line training courses to create and enforce safe sleep environment policies. Subsequently, the SSHC created a sub-committee focused on identifying appropriate, AAP approved on-line training courses for use by caregivers at child care facilities, group child care homes, group child care homes, and infant and toddler child care centers. In addition, members of the SSHC Members and the Nurse Facilitator provide ad-hoc technical assistance (TA) to DHS as needed. The partners provided input for the DHS Safe Sleep Guide for Child Care Providers. The easy to read, user friendly guide

includes information on:

- What is SIDS and SUID,
- simple data infographics,
- AAP recommendations for safe sleep environments, the A, B, Cs (Alone, on the Backs, in a Crib) of safe sleep,
- a checklist of safe sleep environment recommendations (i.e.: Move an infant to a crib or playpen if they fall asleep elsewhere),
- “The Big No-Nos for child care providers” (no smoking, no leaving baby in swing, no baby on couch, no baby on an air mattress/soft surface, no stuffed animals or toys in the crib),
- conversations to have with parents.

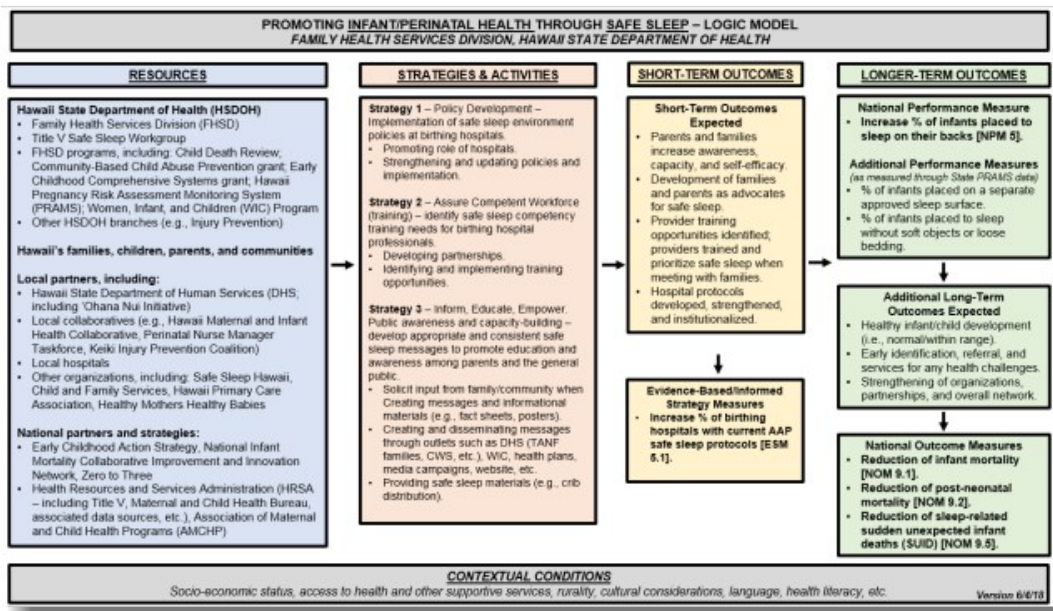
Pack n Play Distribution

Hawaii’s Healthy Mothers, Healthy Babies has a successful “Cribs for Kids” program targeting low-income families through referrals from various agencies. Parents without a safe sleep environment for their child and are willing to participate in a 1-hour educational session, receives education and a free Pack n’ Play (PNP) portable crib. Some of the birthing hospitals also have their own PNP distribution program for low-income, at risk families. Title V is exploring expansion of the Cribs for Kids program.

The PNMTF was unsure of the need for PNP distribution since parents are not consistently asked “Where will your baby sleep at home?” The decision was made to have nurses ask this question for a two-month period during hospitalization and find out what the need is at each hospital. The purpose will be to develop a program so all infants can have a safe place to sleep.

Review of the Action Plan

A logic model was developed for NPM 5 to review the alignment between the strategies, activities, measures and desired outcomes. Strategies 1-3: policy development, assuring a competent workforce (training), Inform, educate, empower; remain unchanged from previous years. By working on these three strategy areas, Hawaii plans to increase the percentage of placed safely to sleep. ESM 5.1 will be completed in FFY 2018 with all the birthing hospitals in compliance with AAP protocols. The activities associated with each of the three strategies directly correlate with short-term outcomes and will impact longer-term outcomes (NPM 5 and NOM 9.1, 9.2, 9.5).



Challenges Encountered

Challenges continue around messaging and education dissemination.

Messaging. Addressing local attitudes and a general acceptance of co-sleeping has been challenging. The practice may be attributed to the state's ethnic/cultural diversity, economic constraints related to the State's high cost of housing which contributes to the sharing of small dwellings and/or multi-family living arrangements. The data indicates certain ethnic groups, young mothers, and low income are particularly at risk; *more than 9 in 10 infants that died to safe sleep factors were not sleeping in a crib or bassinet and nearly 9 in 10 infants who died due to safe sleep factors were sleeping with others at the time of death.* Initiatives such as Pack and Play distribution and education and the local Cribs for Kids Program have proven effective nationally with high risk populations.

Education Dissemination. FHSD will continue to engage other programs (i.e. WIC and Home Visiting), programs based at birthing hospitals and FQHCs, and identify other "non-traditional" partners such as schools and churches.

Overall Impact

By working together with key-stakeholders to address this issue, parents, families, caregivers and the medical community have increased knowledge and understanding of creating a safe sleep environment for infants. Program activities have successfully addressed this issue through a multi-pronged approach consisting of advocacy, policy development, creating a competent workforce, education, safe sleep champions, and grass roots programs/initiatives. These activities combined with input from parents and families and the leadership provided by the PNMTF, SSHP, SSHC, and Title V funded staff have proven successful in mobilizing Safe Sleep efforts. The activities also contributed to the increase in proportion of infants placed to sleep on their backs from 78.6% (2014 PRAMS Data) to 81.5% (2015 PRAMS Data) exceeding the national estimate of 75.8%, and the proportion of infants placed to sleep on their backs has increased significantly since 2007 (71.7%).

It is important to recognize the feedback provided by families related to message development and promotion of safe sleep materials. Families receiving services at DHS's First to Work Program and the Community Children's Council assisted by completing a survey. Although we are still receiving input from families, preliminary feedback suggests keeping the phrase "Child Care Providers...Don't make this mistake" and adding the universal "no-sign" or over picture graphics of a baby left sleeping on a couch or in a crib with stuffed animals and toys in the new Safe Sleep Guide for Parents (target release date Fall 2018). This input ensures the creation of a family-friendly guide. Proven successful, more work needs to be done to engage family input in the next year's activities.

The partnership with Department of Human Services (DHS) will allow safe sleep programs to reach more high-risk populations – young mothers, those on Medicaid, and key ethnic groups.

Perinatal/Infant Health - Application Year

For the Perinatal/Infant Health domain, Hawaii selected 2 performance measures:

- NPM 4 (A & B) Breastfeeding
- NPM 5 (A, B, C) Safe Sleep

Plans for future activities for the three measures are described below.

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

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

For the Perinatal/Infant Health domain, Hawaii selected NPM 4 (breastfeeding) based on the results of the Title V needs assessment. The 2020 Title V state objectives are to increase the proportion of children who are ever breastfed to 94.0%, and to increase the proportion of children who are breastfed exclusively through six months to 28.0%.

Work on the three breastfeeding strategies will continue. Some of the major activities include breastfeeding trainings, analysis of WIC breastfeeding data to inform program planning, and exploration of ways to expand BFPC to neighbor islands.

The breastfeeding state planning effort led by the HMIHC will continue in FFY 2019. The HMIHC's Infant Health & Safety Team refined its breastfeeding logic model to focus on four strategic areas: (1) leadership, (2) messaging & training, (3) laws & policies, and (4) support for families. Other activities will include:

- Continue breastfeeding trainings for service providers who can assist mothers in overcoming common breastfeeding challenges.
- Referring all pregnant moms served by FHSD programs to the Healthy Mothers Healthy Babies "Text4Baby" service.
- Continue collaborating with the Chronic Disease Prevention and Health Promotion Division on the Baby-Friendly Hospital Initiative.

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

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

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

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

For the Child Health domain, Hawaii selected NPM 5 Safe Sleep based on the results of the Title V needs assessment. The 2020 Title V state objective is to increase the proportion of infants placed to sleep on their backs to 83.0%. The Title V-SSHC, PNMTF and SSHP will continue to focus on activities mentioned in the previous section. Key activities for each of the three Safe Sleep strategies to effectively achieve the ESM 5.1 include policy development; assuring a competent workforce; and inform, educate and empower (parents, families and caregivers); collaborate with DHS and provide technical assistance to assure implementation of safe sleep policies and AAP approved trainings on safe sleep summarized below.

The oversight of hospital safe sleep training and the provision of safe sleep information to new parents leaving birthing centers will be led by the PNMTF and the oversight of training for child care providers will be led by DHS with technical assistance from the SSHC. Also, SSHP will provide ongoing technical support, data and recommendations

from child death reviews and the Pregnancy Risk Assessment Monitoring System (PRAMS) data to inform the refinement of safe sleep messages and materials targeting parents and others who care for infants.

Strategy 1: Policy Development.

PNMTF

- Review of safe sleep policies at birthing hospitals.
- Assess, review, monitor safe sleep environment policies at birthing hospitals; assure continued compliance with most current AAP guidelines.
- Discuss enforcing safe sleep environment policies at birthing hospitals.
- Discussion of safe sleep environment protocols at PNMTF (standing agenda item).
- Monthly communication with Perinatal Nurse Managers (PNM) for policy updates.
- Convene at least one in-person meeting to encourage PNMs to promote safe sleep awareness month at birthing hospitals.

SSHC

- Safe Sleep Hawaii Coalition support efforts of DHS as it pertains to safe sleep environment policies.
- RN Facilitator to convene ad-hoc committee to review and approve on-line training courses for caregivers at child care facilities, group child care homes, group child care homes, and infant and toddler child care centers.
- RN Facilitator to continue to provide technical assistance for DHS as needed.

Strategy 2: Assure Competent Workforce

PNMTF

- Identify free/sponsored local trainings on safe sleep for birthing hospital professionals.
- Create a list of free on-line training on safe sleep for birthing hospital professionals.
- Discuss potential of creating a “train-the-trainer” course on safe sleep to sustain training efforts. Work with hospitals to make safe sleep environment guidelines part of required competencies for birthing hospital professionals.

Strategy 3: Inform, Educate, Empower.

SSCP/SSHC

- Develop appropriate and consistent parental education and general awareness safe sleep messages.
- Provide technical assistance on creating safe sleep messages.
- Identify decision-makers, key partners, and resources to develop safe sleep messages for parents and others who care for infants.
- Implement dissemination plan for Safe Sleep Guide for Parents.
- Safe Sleep Hawaii website @ www.safesleephawaii.org – identify resources to update, and revise website.
- Promotion of Safe Sleep Environments and Safe Sleep Hawaii Video.
- Pack n Play Distribution--In collaboration with existing programs (i.e. Cribs for Kids) identify opportunities and secure funding for additional education and pack n play distribution efforts to meet the continuing need in the community especially among risk populations such as the homeless and new families with minimal access to transportation.
- Support Perinatal Nurse Managers Task Force and DHS's effort on safe sleep.
- Engaging other programs (i.e. WIC and Home Visiting); programs based at birthing hospitals and FQHCs;

and identify other “non-traditional” partners such as schools and churches to assist in providing parents and families with information and education on safe sleep environments.

- Evaluate known safe sleep crib distribution and education programs to identify what programs and interventions are effective in addressing at risk populations.
- Conduct analytical studies relating to safe sleep (i.e.: Safe Sleep and Substance Use/Abuse) and disseminate findings to encourage evidence based program planning, policy develop and decision making.

Title V Perinatal/Infant Health Programs

Other Perinatal/Infant Health programs administered by Hawaii Title V that were not discussed in the performance measure narratives.

Women’s Health Clinical and Quality Assurance: strives to reduce risk factors that contribute to infant mortality and lead to poor birth outcomes. Contracts with community providers to offer perinatal support services to high-risk pregnant women through six months post-partum.

Newborn Hearing Screening: provides newborn hearing screening for babies as required by Hawaii state law to identify hearing loss as soon as possible so that children can receive timely early intervention services.

Newborn Metabolic Screening: provides newborn blood spot testing for babies as required by Hawaii state law. The tests help detect rare disorders that can cause serious health, developmental problems and even death if not treated early.

Parenting Support Programs A statewide system of community-based parenting education and family support services through purchase of services contracts and through leadership in statewide early childhood initiatives and consortia. Funded programs recognize and build on parents’ strengths and address their need for information about child development, communication and guidance skills, other life-cycle issues, awareness of community resources, and community and cultural support. Services include a telephone warm-line for parents, caregivers and service providers; short term in-home parenting support; and parent-child interactive parenting education groups for homeless families.

Children and Youth with Special Health Needs: provides assistance with service coordination, social work, nutrition, and other services for children with special health care needs age 0-21 years with chronic medical conditions. It serves children who have or may have long-term or chronic health conditions that require specialized medical care and their families.

Early Intervention Section (EIS) is a federal and state-mandated program that provides services to support the development of infant and toddlers from birth to three years of age.

Hi’ilei Hawaii: is a free resource for parents of children from birth to 5 years old. Hi’ilei provides developmental screening and information for families who are interested in supporting their young child to reach optimal development.

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

Early Childhood Comprehensive Systems: is using the collective impact model to improve young children’s (birth through age five) developmental health and their families’ well-being and focuses on the County of Maui.

Child Abuse and Neglect, Domestic and Sexual Violence Prevention: committed to the primary prevention of all forms of violence and stopping violence before it begins so that all people, families, and communities are safe, healthy, and free of violence. The Family Strengthening & Violence Prevention Unit provides programs statewide for the prevention of child abuse and neglect, sexual violence and domestic violence and support for parents.

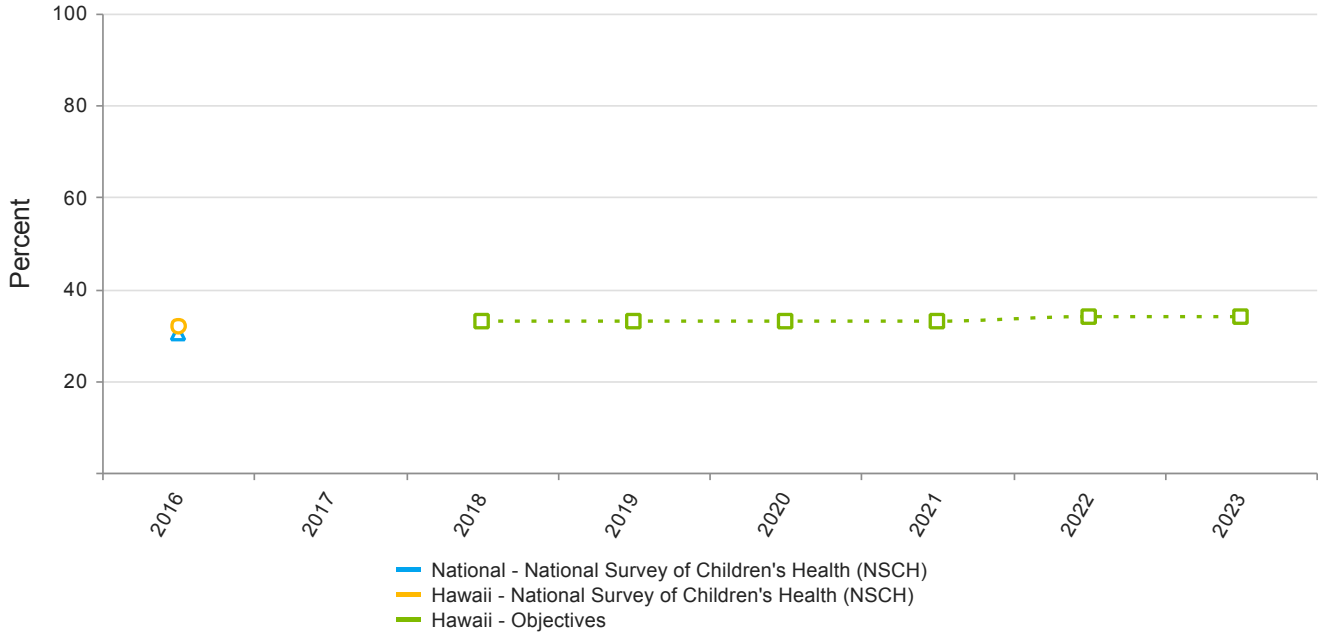
Child Health

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 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016	10.9 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	91.7 %	NPM 6 NPM 13.2

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Baseline Indicators and Annual Objectives



Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	2017
Annual Objective		
Annual Indicator		32.0
Numerator		12,946
Denominator		40,486
Data Source		NSCH
Data Source Year		2016

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	33.0	33.0	33.0	33.0	34.0	34.0

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:	Inactive - Completed
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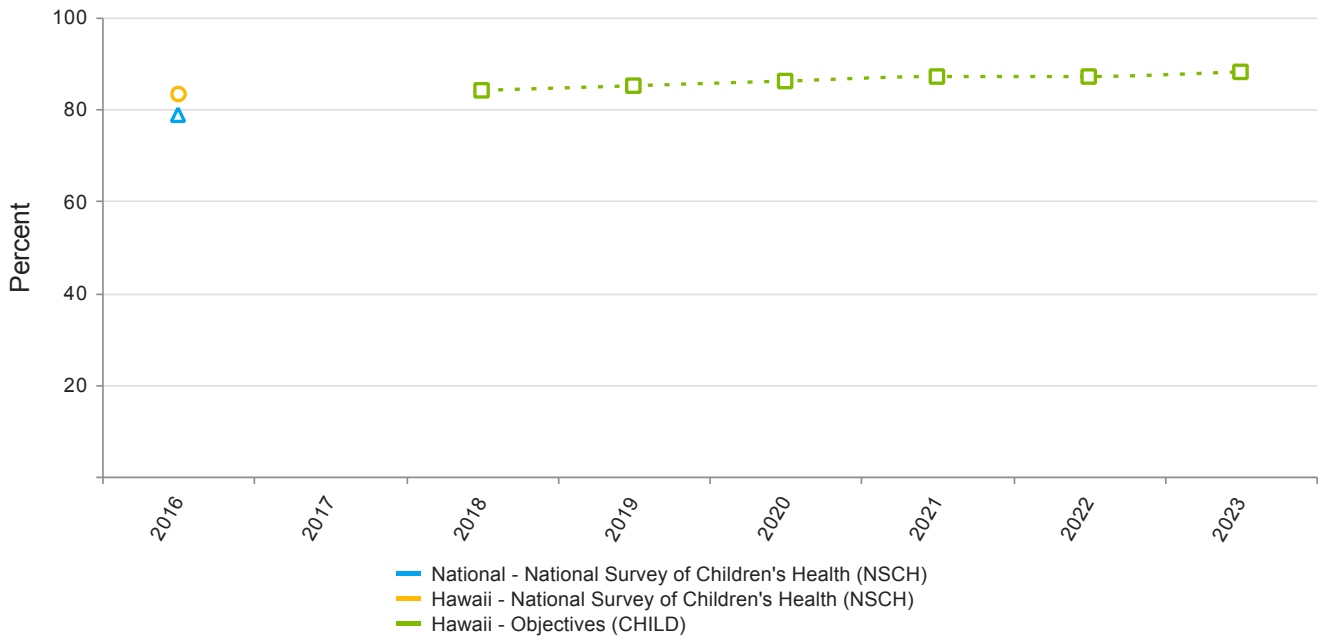
State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	No	Yes
Numerator		
Denominator		
Data Source	Program Data	Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

ESM 6.2 - Develop and Implement Policy and Public Health Coordination (PPHC) rating scale to monitor infrastructure development within FHSD.

Measure Status:	Active
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Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	12.0	18.0	24.0	27.0	30.0

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
Baseline Indicators and Annual Objectives



NPM 13.2 - Child Health

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	2017
Annual Objective		
Annual Indicator		83.1
Numerator		243,681
Denominator		293,312
Data Source		NSCH
Data Source Year		2016

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	84.0	85.0	86.0	87.0	87.0	88.0

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - The establishment of leadership for the State Oral Health Program under the direction of a dental professional and staff with public health skills.

Measure Status:	Inactive - Completed
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State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	No	Yes
Numerator		
Denominator		
Data Source	State Oral Health Program, Family Health Svcs Div	State Oral Health Program, Family Health Svcs Div
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

ESM 13.2.2 - Completion of teledentistry pilot project at three early childhood settings to reach underserved children.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	No	No
Numerator		
Denominator		
Data Source	Virtual Dental Home Planning Team	Virtual Dental Home Planning Team
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

State Performance Measures

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

Measure Status:	Active
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Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	6.0	5.9	5.9	5.8	5.8

State Action Plan Table

State Action Plan Table (Hawaii) - Child Health - Entry 1

Priority Need

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

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

By July 2020, increase the percent of children, ages 10 months 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

Family Engagement and Public Awareness

Data Integration

Policy and Public Health Coordination

Social Determinants of Health and Vulnerable Populations

ESMs

Status

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

Inactive

ESM 6.2 - Develop and Implement Policy and Public Health Coordination (PPHC) rating scale to monitor infrastructure development within FHSD.

Active

NOMs

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Priority Need

Improve the oral health of children

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

By July 2022, increase the percent of children, ages 1 through 17 who had a preventive dental visit in the past year to 87% (Baseline: 2016 NSCH data 83.1%)

Strategies

Develop program leadership and staff capacity

Develop or enhance oral health surveillance.

Assess facilitators/barriers to advancing oral health

Develop and coordinate partnerships with a focus on prevention interventions

Develop plans for state oral health programs and activities

ESMs

Status

ESM 13.2.1 - The establishment of leadership for the State Oral Health Program under the direction of a dental professional and staff with public health skills. Inactive

ESM 13.2.2 - Completion of teledentistry pilot project at three early childhood settings to reach underserved children. Active

NOMs

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Hawaii) - Child Health - Entry 3

Priority Need

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

SPM

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

Objectives

By July 2023, reduce the rate of confirmed child abuse and neglect cases per 1,000 for children to 5.8 per 1,000 (New objective: baseline 6.1 in 2017)

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.

Develop child abuse and neglect surveillance system

Child Health - Annual Report

For the Child Health domain, Hawaii selected 3 performance measures:

- NPM 6 Developmental Screening
- NPM 13.2 Oral Health
- SPM 4 Child Abuse and Neglect Prevention

NPM 13.2 was formerly under the cross-cutting domain. With the new guidance, Hawaii was able to align oral health to the child domain.

SPM 4 is a new state measure this year, but is not a new priority. CAN prevention was identified as a major concern in the 2015 needs assessment and remains a compelling issue in the state. Previously the priority was integrated into NPM 7.1 (which related to injury hospitalizations for young children), but did not align well since CAN-related hospitalizations are a small subset of the total cases. Under the new Title V guidance, the priority was converted to a SPM.

Reports on progress to date for the three measures are described below.

NPM-6: Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed screening tool

Introduction: Developmental Screening

For the Child Health domain, Hawaii selected NPM 6 Developmental Screening based on the 5-year needs assessment. By July 2022 the state seeks to increase the number of children ages 9 through 35 months, receiving a developmental screening to 33.6%. Data from 2016 show that the estimate for Hawaii (32.0%) was similar to the national estimate of 30.4%. With this baseline data, the state objective for 2022 was reset at 34.0% reflecting a 5% improvement over 5 years. There were no significant differences in reported subgroups by health insurance, household income poverty level, nativity, race/ethnicity, sex, and household structure based on the single year 2016 data provided.

Developmental screening is a continuing priority from the 2010 needs assessment. Creating partnerships with other initiatives and programs focused on children's health is the greatest area of need. Hawaii's Title V agency coordinates federal, state and local efforts around developmental screening, referrals, and services. Hawaii recognizes that developmental screening is primarily the responsibility of primary care providers through the well-child visit based on guidance from the Accountable Care Act (ACA) and the Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit. The Hawaii Title V agency works collaboratively with medical partners and others to help ensure all children receive developmental screening wherever children and families are engaged.

Hawaii's Title V agency recognizes its role as a convener to help bring agencies together to collaboratively work with communities to create environments that promote health and well-being of children and families. The Title V role in Developmental Screening promotion includes all the core functions of public health: policy development, assurance, and assessment. At the Division level, the Title V Developmental Screening Work Group (Screening Work Group) continues to address the integration and infrastructure issues focusing on developmental screening and services since several programs incorporate developmental screenings into their scope of services. Leadership for the Screening Work Group remains with the CSHNB Early Childhood Coordinator for Children with Special Health Needs. The Title V Screening Work Group includes representatives from Family Health Services Division (FHSD) and the two Branches. MCHB Home Visiting providers administer the Ages and Stages Questionnaire Third Edition (ASQ-3) and Ages and Stages Questionnaire-Social Emotional (ASQ-SE) to parents, CSHNB Hi'iilei Program

provides developmental screening and follow up for children birth-5 using the ASQ-3, Early Intervention Services (EIS) provides the services as the Individuals with Disabilities Education Act (IDEA) Part C Agency, and FHSD ECCS Impact grant is working on developmental screening on Maui County through the ASQ-3 and ASQ:SE2. The FHSD Coordinators in the counties are also on the Work Group and continue to provide information and guidance in the development of community-based strategies and raise community issues around vulnerable populations.

Others on the Title V workgroup include the Newborn Hearing Screening Program Coordinator and the Children with Special Health Needs Branch Audiologist. These are critical programs regarding screening and child development and are involved in this work. Other states have used WIC as a site to engage families in completing the ASQ:3 since families have time in the waiting room before their appointments. Hawaii may try this approach.

Strategies to address the NPM and objective are discussed below.

Strategy: Systems Development

Develop Guidelines on Screening and Referral

The Hawaii Title V agency worked with partners to develop “Hawaii Developmental Screening and Referral Guidelines for Early Childhood and Community Based Providers” (4-6-17 version). The purpose of the guidelines is to provide basic information for those conducting developmental screening of children ages birth through five years of age. They are based on national resources (American Academy of Pediatrics Policy Statement of Developmental Surveillance and Screening Guidelines; the Centers for Disease Control and Prevention Act Early Campaign, Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents; Caring for Our Children; Head Start Performance Standards; and the National Association for the Education of Young Children). The guidelines are based on a review of national and local best practices and was vetted for input from early childhood providers and key stakeholders. They are located on the Department of Health website and are meant to be shared with those who are doing screening through training and as a collateral resource.

<https://health.hawaii.gov/cshcn/files/2018/04/HawaiiDevelopmentalScreeningGuidelines-1.docx>

Key Partners

Hawaii’s Title V agency does not expend its Title V funds to directly support developmental screening efforts. Hawaii could not do the work on developmental screening without partners from other state departments, agencies, and public-private collaboratives.

Partnership with Key External Departments: By working together towards a common goal, Hawaii is able to leverage resources and expertise from various partners. The Department of Human Services Child Care Program which oversees the Child Care Development Block Grant and Hawaii’s Early Childhood Action Strategy are key partners to reach high need families. Hawaii’s Executive Office on Early Learning (EOEL) is working on a strategic plan for early childhood that includes many measures to promote children’s developmental screening and early intervention. Hawaii has a State Council on Developmental Disabilities (DD Council) and its 5-year State Plan includes activities to promote developmental screening, referrals, and services.

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). Hawaii also has a privately funded Early Childhood Action Strategy (ECAS), which is a statewide public-private effort to increase the number of young children in Hawaii who are born healthy, developing on track, ready for school when they enter kindergarten, and are proficient learners by third grade. Developmental Screening and Services is one of the key strategies of this ECAS effort.

Strategy: Family Engagement & Public Awareness

Work with Family Partner Organizations

Hawaii's Title V programs work with families and parent organizations to ensure families understand the importance of screening and their roles in supporting their children's development. The Family Hui is a non-profit that provides Family Support Groups to families with young children. The Hui promotes development screening directing families to the online Ages and Stages Questionnaire 3 (ASQ:3) and Ages and Stages Questionnaire-Social Emotional (ASQ:SE). Through these efforts the Hui has learned about potential family barriers to screening:

- families are not likely to complete a screening unless there is an existing concern about their child's development.
- at free public events, parents do not complete the screenings unless incentives are offered
- there are still many issues around stigma and shame that must be addressed.

The Title V program conducted a brief survey of parents at the 2017 Children and Youth Day event held at the State Capitol on various child health issues including developmental screening. Parents were asked whether their doctor did a developmental screening on their child: 92% said Yes. Parents were asked where they get information about their child's health: 92% said from their doctor, 53% from their family, 40% from the nurse, 32% from friends, 29% from child care providers, and 18% from other sources (books, classes, online, media, research, etc.). The survey results verify the importance of developing family-friendly, positive messaging on the importance of child development that avoids stigma and shame that may prevent families from seeking supports if there may be a concern about their child's development. Family engagement is a critical piece and more can be done in this area. Fortunately new staff were hired who have a special interest and experience working with families.

Strategy: Data Integration

The Title V Screening Workgroup developed an internal data sharing system to see how many children were screened from MCHB Home Visiting Programs, CSHNB Hi'iilei Program, and the number of referrals to EIS. The Home Visiting and Hi'iilei programs were selected because the programs use the same screening tool (ASQ-3) and serve the vulnerable populations in need of monitoring. The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program targets families identified through a risk assessment conducted in the hospital. Hi'iilei 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 results from the data collection efforts are mixed, as it was challenging to collect consistent data (ages of child) and information across programs. The data submitted now requires further analysis to identify common data elements to determine whether children received appropriate follow-up care.

The Title V work group met with program coordinators to review the initial data collected and identified key findings and recommendations. First, additional information should be collected on referral services to Early Intervention to document referrals from Home Visiting, Hi'iilei, and other programs. This information would be helpful to target promotion efforts.

Second, there is a need to promote developmental screening efforts in non-DOH programs. Additional work is needed to promote the online link to the ASQ-3 screening located on the DOH website through the Hi'iilei program. Third, the data collected provided limited information for quality improvement purposes. The key recommendation was Hawaii needs to have a longitudinal data system to link the number of children screened, referred for services, and receiving services to measure meaningful outcomes for children (number of children enrolled in EIS and transitioned to Part B or other special education services).

Another noteworthy finding was the majority of the concerns from Hi'iilei were in the communication and personal-social domains which is consistent with EIS findings that children's language and communication was of notably the highest concern in the domain of child development. Data from more programs are needed to determine if this is a common issue among Hawaii children compared to national trends. The data could support the need for increased interventions or prevention programs aimed at promoting language and communication.

A review of the data follows and will guide targeted promotion and education activities. Of the children who received a home visit since July 1, 2017, 258 received at least one of the developmental screens within developer-established periods. Of the children who screened positive for developmental delays since July 1, 2017, 18 were referred for services to Early Intervention or to other community services. For the IDEA Part C program, the majority of referrals (1,692) comes from medical providers followed by parents (891), and other health care providers (312). Nine referrals came from DOH home visiting. Other early childhood programs such as preschools/child care or Early Head Start had referrals as well (6 and 19). More outreach can be done to childcare providers to ensure referrals are being made after screenings have been completed.

ESM 6.1 was established to measure progress on the creation of this data sharing system within FHSD to collect the number of screenings, referrals, and services provided to children (ages birth-5) in the MIECHV Program, the CSHNB Hi'iilei Program, and EIS. In FFY 2017 the indicator is Yes. The ESM will be inactivated this year since the system was established. A new ESM 6.2 will be created to measure progress on the strategy areas.

Strategy: Policy and Public Health Coordination

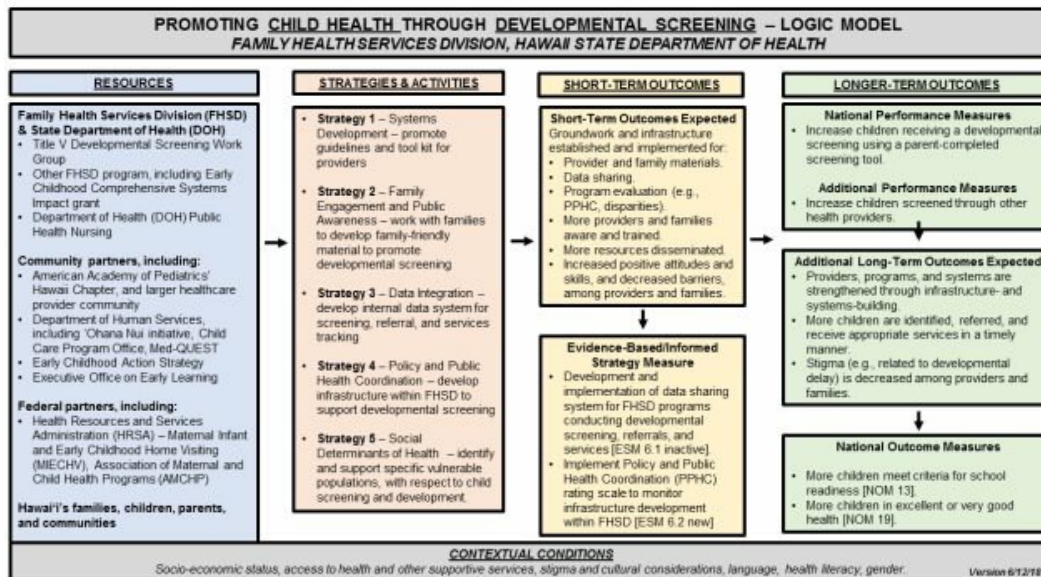
There are many on-going efforts to support the work around policy and the public health role. As part of the requirements of the ECCS Impact grant, Hawaii developed a state-level advisory team consisting of representatives from agencies serving children. Hawaii's team includes representatives from: the Executive Office on Early Learning (EOEL), Early Intervention Section (IDEA Part C), Title V agency, DOH Home Visiting (MIECHV), Child and Adolescent Mental Health Division (children's mental health agency), American Academy of Pediatrics – Hawaii Chapter (Health care providers), Public Health Nursing (Public Health), Head Start Collaboration Office, and Department of Human Services Child Care Administration (early childhood), CDC Act Early Ambassador, DD Council, Hawaii Children's Action Network (advocacy organization), Action Strategy (Philanthropy), Hilopa'a Family to Family Health Information Center (family agency), and the Family Hui (family agency). This group meets quarterly to address challenges that arise at the systemic level and to ensure coordination amongst screening and referral efforts.

Strategy: Social Determinants of Health

Hawaii's Title V agency recognizes that social determinants of health will affect children's development and uses a trauma-informed care approach for dealing with children and families who may have higher risk factors to better support their child's development and mitigate the risk factors. Hawaii has a growing homeless problem and recognizes that children who may be living in homelessness may be more susceptible to developmental delays. One of the state's largest emergency shelters, the Institute for Human Services provides short-term stabilization through shelters that lead to permanent housing. More activities are described in the FFY 2019 plans.

Review of Action Plan

A logic model was developed for the ECCS Impact grant to assure progress and show where there are levers that can help move the efforts. The logic model was modified to include the Title V measures (NPM, ESM, NOM). Strategies were developed by the workgroup with consideration of other community, statewide, and national efforts. Strategies included input from partners and additional feedback from families and providers at conferences and community events. The major strategies for the work plan revolve around the areas of: Systems Development; Family Engagement and Public Awareness, Data Integration, Policy and Public Health Coordination, and Social Determinants of Health.



By working on these five strategies, Hawaii plans to meet its NPM of increasing the number of children receiving a developmental screening using a parent-completed screening tool by addressing systemic challenges, working with families to promote understanding of the importance of completing the screening tool, using data to address areas of concern, working on policy and public health coordination so there is consistent information and guidance, and addressing social determinants of health to determine areas of greatest need. The new Title V guidance changed the developmental screening NPM from ages 10-71 months to 9-35 months to now asks whether the child was screened *in a medical visit to parent completion of the screening tool*. Changes were made based on the AAP recommendations and aligns with the Title V systems efforts which have a broader focus beyond the medical home. The ECCS Impact grant receives technical assistance (TA) from ZERO TO THREE and the National Institute for Children's Health Quality (NICHQ) through the Collaborative Improvement and Innovation Network (CoIIN). The TA provides guidance and information to the Title V Screening Workgroup and efforts.

Based on this year's efforts and seeing that the two areas of unmet needs are addressing Family Engagement and Social Determinants of Health, Hawaii will focus efforts on these two areas for FFY2019. Progress was made in the Systems Development and Policy and Public Health Coordination with the development and implementation of the Screening and Referral Guidelines. Training and promoting the guidelines will continue to ensure screenings and referrals are being made in a timely basis.

Initial review of the data raised critical questions regarding the underlying root causes for developmental delays. It is unclear why Hawaii's children appear to be most susceptible to delays in the language and social-emotional domains. Possible factors may include Hawaii's multi-cultural, multi-ethnic communities where language may be a challenge or the prevalent use of 'Pidgin English' that may contribute to language delays. There may be cultural implications that need to be addressed. The data also shows that Hawaii should improve promotional activities for the Hi'iilei online link to the ASQ to increase the number of children receiving a screening. This free program could be servicing more children in the state.

A new ESM 6.2 was created as a comprehensive measure across all five Developmental Screening strategies. A Policy and Public Health Rating Scale (PPHC) was developed and is discussed in the Plans.

Challenges Encountered

Challenges still remain in the areas of data, policy, and messaging.

Data:

Changes in national data sources hampered efforts to secure trend data for the NPM and assess progress. Also the limited race and ethnicity categories used in NSCH do not help identify the needs of Hawaii's multi-ethnic population, which is dominated largely by distinct Asian and Pacific islander groups. 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 (from CMS Form 416) 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.

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.

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 emphasized 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.

Overall Impact

By working together with partners to address this issue, providers and partners are more aware of the importance of developmental screenings using a validated screening tool and ensuring that referrals are timely and communicated with the medical home. More work can be done in this area but more state partners are now aware of the

importance of this issue and joining efforts to promote screening and referral. There could be more resources available to support families who choose not to continue with a referral to Early Intervention or Special Education because of concerns around stigma, but by normalizing the conversation and making the screenings as part of a well-child visit, helps to ensure these conversations are happening. By working with the American Academy of Pediatrics – Hawaii Chapter and the Med-QUEST leadership, consistent information about the screenings and referrals and the use of the online ASQ is being shared. This will help make a greater impact in Hawaii and it is anticipated that with more promotion of these two tools there will be an increase in the number of children receiving a standardized screening.

Hawaii recognizes it needs to do more work around ensuring there is family-friendly messages to parents about not just the screenings but also the referrals. Another adjustment is that Hawaii will target efforts on the vulnerable populations, primarily in the area of homelessness, as this has become a state priority.

Through working at community fairs and public events, Hawaii promotes the importance of developmental screenings with families and the public. Through trainings to childcare providers on the screening guidelines and providing training on the ASQ and ASQ-SE, Hawaii engages stakeholders. Providers asked for more trainings on the guidelines and on how to share the information with families. Many childcare providers are still not comfortable explaining to a parent that their child may have a delay. One childcare provider who owns a chain of childcare centers said that she stopped sharing this type of information because of liability issues with families who may feel that her program is targeting their child. More education about the proper use of the tool and sharing of information will be conducted based on this feedback.

Based on feedback from families gathered at community outreach events, families may recognize the ASQ and know that it was completed for their child but some do still not understand why their child was screened. Home Visitors and childcare providers may ask families to complete the ASQ therefore families may recognize the questionnaire, but may not realize the importance of it. In addition, many families may complete the screening and are choosing not to follow up with referrals if there are concerns. More information on why families are choosing not to follow through with referrals is needed and the Title V workgroup will develop a survey to identify the reasons families are choosing not to follow up with referrals. More work needs to be done around family engagement and this will be the focus for the next year's activities.

NPM 13.2 Percent of children, ages 1 through 17 who had a preventive dental visit in the past year.

Introduction: Oral Health

For the Child Health domain, Hawaii selected NPM 13.2 children's oral health based on the 5-year needs assessment. With the flexibility afforded by the new Title V grant guidance Hawaii elected to delete NPM 13.1 (oral health for pregnant women) as this concern is not a priority among oral health or maternal-infant health stakeholders now.

By July 2022 the state seeks to increase the percent of children, ages 1 through 17 who had a preventive dental visit to 87.0%. Data from 2016 show that the estimate for Hawaii (83.1%) was higher than the national estimate of 78.7% for preventive dental visit among children. With this baseline data, the state objective for 2022 was reset at 87% reflecting a 5% improvement over 5 years. Children 1-5 years of age had a lower estimate (64.7%) compared to children 6-11 years (92.8%) and 12-17 years (91.1%) of age. There were no other significant differences in reported subgroups by household income poverty level, language spoken at home, nativity, race/ethnicity, sex, and household structure based on the single year 2016 data provided.

Although data from population based surveys indicate Hawaii's rates of oral health status and service utilization are similar to the rest of the U.S., clinical data reveal a different story from the self-reported information. A 2015 oral health Basic Screening Survey revealed Hawaii's third graders have the highest rate of caries in the U.S. and some

of the highest rates of urgent care among the states. Low-income, those with Medicaid coverage, and Native Hawaiian, and Pacific Islanders suffer disproportionately throughout the state.

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, at 11.7%. Only Hawaii federal military bases have fluoridated drinking water. 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.

The critical nature of Hawaii's oral health has been reflected in the five consecutive "F" grades received by the Pew Charitable Trusts as state report cards in children's oral health. While not mandated, the Hawaii State Department of Health (DOH) does have statutory responsibility for assessing state dental needs and resources, planning and providing services, conducting education and training and applying for federal funds.

To address the oral health priority, the Hawaii State Department of Health applied for, and received, a 5-Year Centers for Disease Control and Prevention (CDC) oral health state infrastructure building grant in 2013. 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). The grant was critical to rebuild the SOHP which was eliminated in the 2009 recession. FHSD, the Title V agency, is the lead for oral health and administers the grant. The five NPM strategies are taken from the CDC oral health grant.

Strategies to address the NPM and objective are discussed below.

Strategy: Develop program leadership and staff capacity

The importance of dental program leadership cannot be understated. With no local health departments, the SOHP is key in providing statewide leadership for critical public health surveillance, evaluation, planning and prevention functions. Given the state's unique diversity in ethnicity, language and cultural practices, many best practices may not translate to Hawaii. With no dental school, the SOHP plays an important role to promote evidence-based oral health practices in both public and private settings by supporting workforce training, policy guidance, and research.

In 2017, FHSD fully staffed the SOHP with a Dental Director, Program Manager, and Office Assistant. The FFY 2017 and 2018 indicator for ESM 13.1 is "Yes". The State Oral Health Program (SOHP) is fully staffed with a Dental Director, Program Specialist/Manager and Office Assistant. The Dental Director provides overall leadership and direction for the SOHP. He is pediatric dentist with a private practice who is employed with the Department on a half-time basis. His position provides overall direction and vision to the program. The Program Specialist is a public health professional with experience in large-scale, statewide project management. Her position is full time and she is responsible for daily operations and the management of the SOH program. The Office Assistant is a half-time position who provides overall administrative support.

Although securing dedicated staffing was the top priority for the SOHP, there were major challenges and barriers to achieving progress in this area. The three major barriers with filling the Dental Director position: a low salary when compared to potential earnings in private practice, restrictive dental licensing requirements within the state of Hawaii, and a limited number of dentists with public health training and experience. Because Hawaii does not have a dental school, the pool of qualified dentists is limited to practicing clinicians. Other contributing factors are the relative geographic isolation of the state from the continent and the high cost of living. Other challenges included protracted personnel and procurement processes which required extensive time and effort to establish the positions, hired staff who vacated the positions, and changes made to the staffing plan to best utilize the limited grant funds.

Although Hawaii experienced challenges to fill the SOHP vacancies, FHSD began utilizing the grant funds in Year 1 to build surveillance capacity, conduct an environmental scan, promote partnerships, and initiate other oral health activities to lay the foundation for state planning in Year 5. Salary savings were utilized to contract services while the dental positions were being established and filled. A diverse team of FHSD staff was assembled to plan and manage the activities. None of the staff were dental professionals. Content expertise was largely provided by Association of State and Territorial Dental Directors (ASTDD). DOH also obtained guidance from the CDC program officers.

ESM 13.1 was selected to assure progress on this foundational strategy for the SOHP: assuring the program has qualified leadership, a dental professional and staff with public health skills. 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’. The FFY 2017 indicator for this measure is a resounding Yes. The ESM will be inactivated since it has been achieved.

Strategy: Develop or enhance oral health surveillance

Following the state oral health surveillance plan, the SOHP proceeded on planning and securing a contractor to conduct a second Basic Screening Survey (BSS) for young children enrolled in Head Start programs. A scope of work was developed and the Hawaii Children’s Action Network was contracted to conduct a statewide BSS reaching all enrolled Hawaii Head Start and Early Head Start children. A Steering committee was formed to manage/monitor project progress. Members includes the State Head Start Collaboration Office, ASTDD’s epidemiologist, public health nursing, and the Hawaii Primary Care Association. Agreement to participate in the BSS was secured from all Head Start/Early Head Start programs. The BSS methodology, scope and screeners training was conducted with assistance from ASTDD. Screeners were recruited through the Hawaii Dental Association, the Hawaii Dental Hygiene Association in addition to screeners used in the previous 3rd grade BSS. Supplemental funding for the project was awarded by the Hawaii Dental Service Foundation, the local Delta Dental affiliate. Screenings began in August 2017 and were completed in May 2018. A final report is due in August 2018.

An additional data publication was developed to support community outreach efforts for the development of a state oral health strategic plan.

Strategy: Assess facilitators/barriers to advancing oral health

Several activities were conducted to assess facilitators/barriers to advancing oral health. An environmental scan report was completed which was contracted by the SOHP. The report included a data review, key informant interviews, key findings and recommendations.

To kick-off a year-long state strategic planning process, a stakeholder survey was broadly disseminated electronically by planning contractor, the Hawaii Public Health Institute, to identify key issues/concerns regarding oral health. Additionally, Town Hall meetings were conducted across the state to capture feedback from stakeholders and the community with regards to oral health needs and input for a statewide strategic plan. The final plan is scheduled for completion in August 2018.

Develop and coordinate partnerships with a focus on prevention interventions

The CDC oral health grant requires the SOHP work to build partnerships through all its projects. Partnerships have allowed Hawaii to leverage limited resources to achieve public health functions. One major example of these beneficial partnerships is the Virtual Dental Home (VDH) teledentistry project. The project is funded by a grant from the Hawaii Dental Services Foundation (the local Delta Dental affiliate) for the pilot. The DOH Developmental

Disabilities Division's Hospital and Community Dental Services Branch, which operates several DOH dental clinics on Oahu, is the project lead. The Pacific Center for Special Care (PCSC) at the University of the Pacific, Arthur A. Dugoni School of Dentistry provides technical assistance. PCSC created the VDH system of oral health care which has been successfully deployed in California and is being replicated in Colorado and Oregon in addition to Hawaii. This system has been shown to reach people who do not traditionally receive dental care until they have advanced disease, pain and infection.

FHSD, as the Title V agency, participates on the VDH project planning team because the populations targeted are underserved children and because the Women, Infant, and Children (WIC) services, one of FHSD's three branches, is participating. This measure also supports FHSD's state priority to promote telehealth in Title V programs.

The project is currently in its third and final year (2016-2018), with West Hawaii Community Health Center (WHCHC), a Federally Qualified Health Center (FQHC), serving as the project dental provider. The population served is low-income and underserved children aged 0-5 years old and includes Head Start Programs, a WIC site, a Traveling Preschool, and a Transitional Housing program.

A WHCHC dental hygienist and dental assistant comprise the community dental team. This team provides preventive dental services and collects diagnostic records at the community site. This community dental team works three days a week, rotating between the sites.

Two dentists, located at the WHCHC dental clinics, review patient records that include digital intraoral photos and radiographs that are uploaded to a secured cloud site by the community team for review by the dentists. The photos and x-rays are not reviewed in real time, but at the convenience of the of the dentists, including before and after clinic hours and during openings in the clinic schedule (including downtime created by last minute patient cancellations). Based on the review, the dentists diagnose and complete the exam and develop treatment plans. These dentists also provide dental care to patients who are referred to the WHCHC dental clinic for complex treatment by the community dental team.

Virtual Dental Home – Dental Care in the Community

The Virtual Dental Home (VDH) is a community-based oral health delivery system in which people receive dental diagnostic, preventive, and early intervention services in non-clinical community settings such as schools, WIC, Head Start sites, low-income community centers, and nursing homes. VDH reaches people where they live, work or receive educational or social services, significantly reducing the need to travel to receive dental care.

The VDH model uses portable dental equipment and telehealth technology to link dental hygienists and dental assistants in the community with dentists in dental offices and clinics; facilitating access to a full dental team and comprehensive dental care. Community-based dental hygienists and dental assistants collect dental records and provide preventive care for patients in community settings. See figure 1.



Figure 1 – Dental hygienist collecting dental records and providing preventive dental care such as fluoride applications, teeth cleanings, and dental sealants in an elementary school, and a WIC site

The community-based clinical team provides information through a secure web-based cloud storage system to a

dentist at a clinic or dental office who completes a diagnosis and creates a dental treatment plan via teledentistry (store and forward modality) See figure 2.



Figure 2 – Diagnostic records for patient (intraoral photographs, teeth charting, and digital x-ray). Dentist reviewing records for diagnoses and treatment plan.

Patients who require more complex treatment that only a dentist can provide are referred and receive assistance scheduling a dental appointment. After the complex treatment is completed by a dentist, the patient is referred back to the community site for future preventive dental care and dental records collection such as semi-annual dental preventive visits.

ESM 13.2 focuses on the completion of a pilot demonstration project for teledentistry using the Virtual Dental Home System of Care (VDH) model developed by UOP. This measure also supports one of Hawaii's State Performance Measures to promote telehealth in Title V programs. The measure is "Completion of a teledentistry pilot project at three early childhood settings to reach underserved children." The measure is tracked by a 'Yes' or 'No'. 'Yes' refers to the completion of the 15 specific project activities. 'No' indicates the project is still in progress. The FFY 2017 indicator is No. Most of the 15 project activities have been completed. The three-year pilot is set for completion in FFY 2018 when an evaluation and economic analysis is completed and a final report and findings are disseminated. Over 400 children have been provided services through Year 2 of the project; far exceeding initial estimates.

Some of the issues that emerged during the project include securing Medicaid reimbursements for services. Because Hawaii has a telehealth parity law, Medicaid began accepting billing requests for telehealth services in 2018. WHCHC submitted billings for VDH services and is awaiting payment. It is also unclear whether Medicaid will reimburse telehealth related costs for intraoral photos and radiographs, items not normally part of a regular dental visit. Lastly, policy changes made in the 2017 Legislature to the Hawaii Dental Practice Act prohibit hygienists from effectively participating in VDH. An Administration bill was introduced and passed into law in 2018 that exempts hygienists practicing in a public health setting from 2017 change.

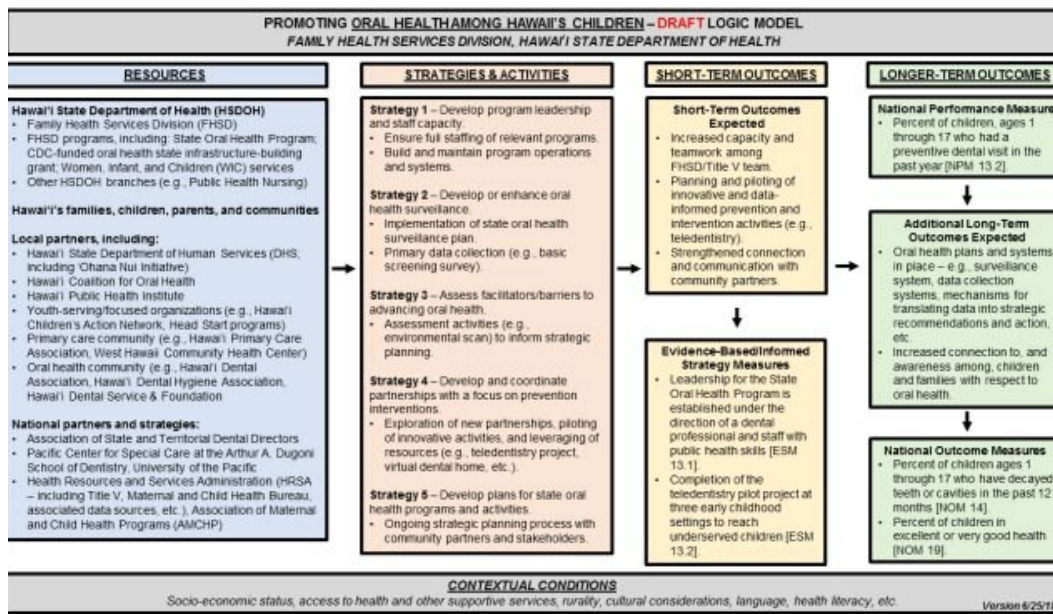
Project Activity	FFY 2017 10/1/15-9/30/17
1. Demonstrate need for project and barriers/facilitators that exist.	Completed
2. Educate and inform community oral health stakeholders and others about the teledentistry delivery of care system and applications to Hawaii.	Completed
3. Develop planning committee for teledentistry projects.	Completed
4. Develop proof of concept for teledentistry projects.	Completed
5. Secure funding for three-year pilot project.	Completed
6. Develop program orientation for community partners, providers, and site staff to introduce concept.	Completed
7. Identify locations and execute Memorandum of Understanding with three pilot sites.	Completed
8. Develop program protocols and policies and procedures for both dental services and case management.	Completed
9. Develop consents and other communications to parents.	Completed
10. Purchase dental equipment and computer software.	Completed
11. Provide necessary training for providers and site staff.	Completed
12. Develop evaluation plan including economic feasibility analysis.	Ongoing
13. Teledentistry operational at three sites.	Completed
14. Provide adequate case management to ensure participants establish a dental home.	Completed
15. Inform public of project results, lessons learned, and future considerations.	Ongoing

Strategy: Develop plans for state oral health programs and activities

As noted earlier, the SOHP initiated a yearlong strategic planning process which began with stakeholder surveys, revitalizing the state oral health coalition (Hawaii Coalition for Oral Health), town halls meetings on each of the islands. The process culminated in a statewide meeting to in May 2018 to review of draft plan. The final draft is slated for release in August 2018.

Review of Action Plan

A logic model was developed for the CDC oral health grant to assure progress and show where there are levers that can help move the efforts through a collective impact approach. The logic model was modified to include the Title V measures (NPM, ESM, NOM). With the flexibility afforded by the new Title V grant guidance Hawaii elected to delete NPM 13.1 (oral health for pregnant women) as this concern is not a priority among oral health or maternal-infant health stakeholders now.



Hawaii will meet its NPM

Overall Impact

The CDC oral health grant 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 consultation to assure continued progress on the five strategy areas. FHSD continues to benefit from ongoing ASTDD TA on virtually all strategy areas for the cooperative agreement. ASTDD TA is invaluable for content expertise and guidance since the SOHP has not had a dedicated dental professional or oral health epidemiologist on staff until recently.

Other assets that 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 over the last several years was the personnel vacancies which were addressed with all three positions now filled.

An additional challenge was securing sustainable funding for the SOHP. Currently, the SOHP is solely funded through the CDC grant. The grant amount limits the number of full-time employees that the SOHP can maintain, which impacts recruitment and retention. Additional funding sources will be needed to support increased program development activities including a state school sealant program and community water fluoridation.

Challenges for VDH include:

- Educating oral health professionals and stakeholders on the use of teledentistry technology
- Securing funds for the Virtual Dental Home projects
- Hawaii State Medicaid dental program did not cover dental procedures completed via teledentistry at the start of the Hawaii VDH project (January 1, 2017)

As noted earlier, the 2017 Legislature inadvertently amended the Hawaii Dental Practice Act was to require additional dentist general supervision requirements for dental hygienist in public health settings. These new requirements hindered the efficiency of the VDH in its operations and treatment flow and added additional operating cost. However, a bill to amend the law was passed in 2018 and is pending Governor’s signature.

SPM 4: Rate of confirmed child abuse and neglect cases per 1,000 children aged 0 to 5 years.

Introduction: Child Abuse and Neglect in Hawaii

For the Child Health domain, Child Abuse and Neglect (CAN) remains a continuing priority based on the five-year needs assessment. CAN (also referred to as child maltreatment) remains a critical health concern in the community, with ongoing coverage in the local media of high-profile CAN cases highlighting the need for improved primary prevention services and agency responsiveness. Originally, Hawaii aligned this priority with NPM 7, which addresses hospital-related injuries. However, this proved not to be a specific enough benchmark to measure progress specific to CAN prevention, given that hospital-related injuries result from many causes. With the flexibility of the new Title V grant guidance, Hawaii elected to retain CAN prevention as a SPM, evaluated by a new benchmark (i.e., confirmed cases).

In 2017 (the latest available data), 50% of confirmed CAN cases occurred among children ages 0 to 5 years old. For this age group, the rate per 1,000 children has held relatively steady since 2012 (see table below).

	Confirmed CAN cases among children ages 0 to 5	Rate per 1,000
2012	677	6.5
2013	663	6.4
2014	689	6.6
2015	740	7.1
2016	666	6.4
2017	635	6.1

When examining confirmed CAN cases among all ages for 2017, almost 51% were children of Native Hawaiian or Pacific Islander ancestry, with Native Hawaiian children being the majority at 42.2%. By maltreatment type, 64% of children experienced neglect or medical neglect, 31% suffered psychological abuse, 29% were sexually abused, 36% were threatened with harm, and 29% experienced physical abuse (Hawaii Department of Human Services, Child Abuse and Neglect in Hawaii, 2017).

A combination of individual, relational, community, and societal factors contribute to the risk of CAN including, but not limited to, parents’ lack of knowledge about child development and parenting skills, family disorganization, intimate partner violence, living in a high poverty community, residential instability, and poor social connections. The 2017 Hawaii Department of Human Services report found that among confirmed cases, 9% of children were vulnerable for abuse or neglect due to lack of tolerance to the child’s behavior, and 5.6% of the children’s parents had a history of abuse as a child. Other family risk factors included alcohol abuse (8.9% of confirmed cases), drug abuse (46%), chronic family violence (15.2%), and interpersonal violence (12.7%). Community risk factors included inadequate housing (7.2%) and social isolation (0.5%).

With regards to special needs children, studies have shown that children with disabilities are at least three times more likely to be abused or neglected than their peers without disabilities. Data from the US Department of Education report there are currently 19,375 Hawaii children being served in accordance with the Individuals with

Disabilities Education Act (IDEA) Part B. This includes 2,491 children 0 – 3 years, and 16,884 children 6 – 21 years. There are 13 categories of disabilities that a child may fall under - intellectual disability, hearing impairment, speech or language impairment, visual impairment, emotional disturbance, orthopedic impairment; other health impairment, specific learning disability, deaf-blindness, multiple disabilities, autism, traumatic brain injury, and developmental delay. Statistics on the number of children with disabilities specifically within the child welfare system are difficult to obtain for many reasons. Although systematized data collection is done through the National Child Abuse and Neglect Data System (NCANDS), there is no requirement to report on the types of disabilities or the number of children with disabilities who are older than age 3 when they enter the child welfare system. NCANDS is a voluntary data collection system that gathers information from all 50 states, the District of Columbia, and Puerto Rico about reports of child abuse and neglect.

The potential short- and long-term effects of CAN are also well-studied. Adverse childhood experiences (ACEs), which includes CAN/child maltreatment, are traumatic events that occur before age 18. ACEs include all types of abuse and neglect as well as parental mental illness, substance use, divorce, incarceration, and domestic violence. ACEs include:

- Emotional abuse
- Physical abuse
- Sexual abuse
- Emotional neglect
- Physical neglect
- Mother treated violently
- Household substance abuse
- Household mental illness, including maternal depression
- Parental separation or divorce
- Incarcerated household member

In Hawaii, findings from the 2016 National Survey of Child Health found that 43% of children experienced one or more ACEs. For children age 0 – 5 years, almost 22% experienced one ACE, and 15.5% experienced two or more ACEs. Local data also demonstrated the impact of ACEs on children's ability to flourish/thrive. An FHSD study found that only 39% of Hawaii children 6 months to 5 years of age who experienced 2 or more ACEs are flourishing, compared to same age children who experienced no ACEs – a gap of 34%.

ACEs are linked to adult risky health behaviors, chronic health conditions, low life potential, and early death. Research also shows that ACEs can have a tremendous impact on future violence victimization and perpetration. Such research findings highlight the lifelong impact of ACEs, and underscores the urgency of prevention activities to protect children from these and other early traumas. Protective factors such as living in a supportive family environment, having social networks, parents that are employed, and communities that support parents and take responsibility for preventing abuse, can and do make a significant difference in a child's life and their family's life.

Hawaii's Family Support and Violence Prevention Section (FSVPS) is composed of the three violence prevention programs -- sexual violence, domestic violence, and child abuse and neglect (which partners closely with the Home Visiting program). Violence is a serious problem that is experienced across the lifespan. Violence also takes different forms (e.g., child maltreatment, intimate partner violence, sexual violence), and these expressions of violence are often interconnected. Thus, FSVPS programs recognize that multiple forms of violence often share common root causes, and that CAN prevention is relevant with all. By collaborating and pooling resources on topics relevant to child maltreatment prevention, FSVPS programs reach larger audiences and expand the understanding of the interconnectedness among all forms of violence prevention across these stakeholders.

The approach taken by the Hawaii CAN prevention program specifically, is to strengthen and nurture healthy families by promoting and supporting the protective factors. Program aims follow the levels of the social ecological model (SEM – individual, interpersonal, organizational/community, society): 1) Supporting children and families by reducing their risk of experiencing violence and investing in healthy babies and families; 2) Taking health to where people live, work, learn, and play; and 3) Creating a culture of health throughout the state. Corresponding objectives include: 1) Supporting parents and extended family after the birth of a child to create a healthy home environment and community; 2) Promoting safe and nurturing home environments for families through home visitation and violence prevention programs; and 3) Plan for a system of care for adolescents that addresses physical and emotional health.

The Child Abuse and Neglect Prevention (CANP) program is primarily funded by the Administration for Children and Families, Children's Bureau, under the Community-Based Child Abuse Prevention (CBCAP) grant. The purpose of the program is to: 1) Support community-based efforts to develop, operate, expand, enhance, and coordinate initiatives, programs, and activities to prevent child abuse and neglect; 2) To support the coordination of resources and activities to better strengthen and support families to reduce the likelihood of child abuse and neglect; and 3) To foster understanding, appreciation, and knowledge of diverse populations in order to effectively prevent and treat child abuse and neglect. The CANP program works in collaboration with Hawaii Home Visiting, Sexual Violence Prevention, and Domestic Violence programs. Because of the complexity of risk factors relevant to the prevention and reduction of CAN, this program also collaborates with diverse private and public organizations in the community, including those that directly engage in CAN work, as well as agencies that work on higher level (e.g., housing, employment, safe neighborhoods, etc.).

The Maternal, Infant, and Early Childhood Home Visiting Program supports the Hawaii Home Visiting (HHV) Program by providing voluntary, evidence-based home visiting services to at-risk pregnant women and parents with young children. The goals of HHV are to: improve maternal and child health, prevent CAN, encourage positive parenting, and promote child development and school readiness. HHV follows Healthy Families America, Parents as Teachers, and Home Instruction for Parents of Preschool Youngsters (HIPPPY) that are all evidence-based home visiting models.

Primary prevention - stopping [sexual violence](#) before it begins - is the cornerstone of the sexual violence prevention (SVP) program. This program employs comprehensive prevention strategies using a [public health approach](#) which includes a [continuum of activities to address the way individual, relationship, community and societal factors](#) impact sexual violence. The SVP's three primary initiatives are: 1) *Coaching Boys Into Men*, an evidenced-based curriculum that educates youth on healthy relationships; 2) Hawaii Community Action Teams (CATs) that work in communities to implement social norms approaches to promote safe, stable, and nurturing relationships and environments; and 3) the Prevention, Awareness, Understanding (PAU) Violence Program, a University of Hawaii systemwide program providing prevention education, events, and trainings to raise awareness on issues of gender based violence. SVP activities are funded by the Centers for Disease Control and Prevention, the Rape, Prevention, Education Program (RPE), and State funds from the Domestic Violence and Sexual Assault Special Fund.

The Domestic Violence Prevention (DVP) program also uses a public health approach to end intimate partner violence. DVP is funded by the Domestic Violence and Sexual Assault Special Fund administered by the Hawaii State Department of Health (DOH), Family Health Services Division (FHSD), Maternal and Child Health Branch (MCHB). A key program focus is the management of the Domestic Violence Fatality Review and the Child Death Review. These reviews are critical in identifying prevention strategies needed to reduce and end domestic violence in Hawaii.

Strategies to address SPM 4 and its objectives are discussed below.

Strategy 1: Collaborate on and integrate child wellness and family strengthening activities among programs.

Because families at risk of child abuse or neglect often face challenges in multiple areas of their lives, effective collaboration with a variety of service providers and systems is essential to supporting families' many unique needs. By actively finding ways to partner with other organizations, we are able to better address the systems that impact families, reduce duplication of services, and prevent CAN. Also, working with cross-sector partners who have a vested interest in child abuse prevention can improve service delivery systems and increase effectiveness of programs. Title V's CANP program plays a key role within the statewide network, facilitating teamwork and ushering stakeholders towards a shared goal. Specific activities include the funding of conferences, ensuring active membership on planning committees, supporting networking opportunities, and serving as the convener of coalitions/taskforces and workgroups.

Within the DOH FHSD, active CAN prevention partners are: Child Death Review, Domestic Violence Prevention, Sexual Violence Prevention, Domestic Violence Fatality Review, Home Visiting Program, and the Pregnancy Risk Assessment Monitoring System. External to the FHSD, the DOH Emergency Medical Services and Injury Prevention Systems Branch works on CAN prevention initiatives with the Home Visiting Program. The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV Program) supports the Hawaii Home Visiting Program (HHVP) and provides voluntary, evidence-based home visiting services to at-risk pregnant women and parents with young children, particularly those considered at-risk. Staff provide necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn. In fiscal year 2016, home visitors in Hawaii made 4,407 home visits to 828 parents and children, serving a total of 429 families across all four counties. In addition, 409 new parents and children were enrolled into the program. FHSD also administers family strengthening contracts for parenting and child development services statewide including a telephone warm-line for parents, caregivers and service providers; the dissemination of child development information including community resources; short term in-home parenting support; and parent-child interactive parenting education groups for homeless families. The contracts provide resources and services to families to help prevent CAN.

Other state departments collaborating on CAN prevention work are the Department of Human Services (DHS), Child Welfare Services, the Judiciary, and the Department of the Attorney General.

Collaboration continued with the Early Childhood Action Strategy (ECAS) 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. FSVPS leads for CAN, DVP, and SVP are active participants in the Initiative's 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.

To ensure statewide reduction of CAN, the FSVPS partners with neighbor island FHSD staff at the District Health Offices (DHO) on Maui, Kauai, and Hawaii Island to provide violence prevention trainings and TA. DHO staff 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

program planning and policy development.

The neighbor islands' most robust CAN prevention collaborative is Maui's Ho'oikaika Partnership, a coalition of more than 60 Maui County agencies and individuals committed to preventing child abuse and neglect. At present, the Partnership is focusing on increasing overall awareness of CAN and expanding knowledge of the importance of protective factors in preventing CAN. The Partnership was instrumental in providing Maui County coalition members with training and education around protective factors. Ho'oikaika focuses on protective factors and family strengthening using a strengths-based, family-centered approach. This approach reinforces the CDC's CAN prevention recommendations to promote family support and connectedness at the relationship level of the social-ecological model.

Other key partners in CAN prevention include an array of public and private agencies and organizations. In addition to the Neighbor Island CAN Coalitions, other essential partners funded to reduce child abuse and neglect include, but are not limited to: Early Childhood Action Strategy and Collaborative, Domestic Violence Action Center, Hawaii Children's Trust Fund, Healthy Mothers Healthy Babies, Prevent Child Abuse Hawaii, and Keiki Injury Prevention Coalition. Federal partners include: Centers for Disease Control and Prevention, Department of Health and Human Services (Administration for Children and Families and Children's Bureau), and Health Resources and Services Administration (Title V and Maternal and Child Health Bureau).

Strategy 2: Develop a child abuse and neglect (CAN) surveillance system.

In 2003, the Institute of Medicine recommended that, "*Every public health agency regularly and systematically collect, assemble, analyze, and disseminate information on community health status to carry out the assessment function.*" Public health agencies accomplish this task through ongoing and systematic collection, analysis, and interpretation of health data. Surveillance is vital for planning, implementing, and evaluating public health practice, and should also be aligned with data dissemination to public health decision makers and other stakeholders. The over-arching purpose of public health surveillance is to provide actionable health information to guide public health policy and program.

With regards to CAN, the lack of consistent information about the number of children affected by maltreatment limits the ability of the public health community to respond to the problem in several ways. These are laid out in CDC's 2008 report on child maltreatment. First, it limits ability to gauge the magnitude of child maltreatment in relation to other public health problems. Second, it limits ability to identify those groups at highest risk who might benefit from focused intervention or increased services. Finally, it limits ability to monitor changes in the incidence and prevalence of child maltreatment over time. In turn, this hampers our ability to monitor the effectiveness of ongoing child maltreatment prevention and intervention activities.

In Hawaii, public and private organizations collect data that, when put together, could present a clearer and accurate understanding of CAN in the islands. The biggest challenge is fragmentation of data sources due to separate program purposes, reporting time periods, and data collection methodologies. Also, data standards are often limited or missing. There are no common ways the data are defined, collected, analyzed, used, and shared, despite the fact the programs often target the same families for services and information. Therefore, Title V is committed to convene stakeholders and lead a process to identify existing and needed data, break down silos among existing data sources, and establish a statewide CAN surveillance system that will better inform prevention programs, policies, and systems.

Strategy 3: Raise awareness about the importance of safe and nurturing relationships to prevent child abuse and neglect.

The primary activities under this strategy include awareness-building, parent engagement, and parent education

training. FSVPS programs coordinate large- and small-scale activities year-round and across all islands. Events take place at a range of public sites such as shopping malls/centers, libraries, and parks, to maximize reach to the public. Staff provide families with resource materials and information on child development and parenting tips. Specific examples of awareness and training activities are described below.

Large-scale annual events often coincide with the specific months designated to violence prevention topics. For example, April is recognized as Child Abuse and Prevention Month. Each year, hundreds of blue and silver pinwheels (the national symbol for child abuse prevention) are displayed across the islands at schools, military bases, government buildings, and other sites. Sexual Assault Awareness Month is also recognized in April, and is filled with events and activities highlighting sexual assault as a public health, human rights, and social justice issue, and reinforcing the need for prevention efforts. 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.

Evaluation of such public events can be challenging, expensive, and require considerable time. That said, a small, non-scientific evaluation component was built into Hawaii's pinwheel events, in partnership with the Girls Scouts. The Scouts learned about the risk factors associated with CAN and the factors that can protect a child from abuse or neglect. After the presentation and discussion, the Scout leaders and Scouts took part in a brief survey that asked what they learned about CAN. The survey validated increased awareness about the issue.

The Hawaii Children's Trust Fund (HCTF) is a legislatively-created public-private partnership between the Department of Health and the Hawaii Community Foundation. The mission of HCTF is to ensure that Hawaii's children develop into healthy, productive, and caring individuals by promoting the advancement of community family strengthening programs to prevent child abuse and neglect. To accomplish their mission, the Trust has invested approximately \$8.1 million in child abuse and neglect prevention programs over the years, including public awareness efforts. In 2017, the Trust funded nine community-based prevention programs focusing on young parents of young children. The programs were required to address at least two protective factors in their work. Public awareness efforts focused on CAN prevention public service announcements (PSAs). Evaluation of the PSAs included the number of "clicks" to the website, and more importantly, increase in funds donated through the Hawaii State income tax form check-off box.

With respect to parent training, the Home Visiting Program provides supportive parent education and nurturing activities with the over-arching purpose of improving the health and well-being of families. Trainings focus on promoting child development, encouraging positive parenting, and working with caregiver participants to set attainable goals for the future.

Strategy 4: Provide community-based training and technical assistance promoting safe, healthy, and respectful relationships to prevent child abuse and neglect.

The violence prevention community in the islands is well represented by private and public agencies and programs. Major stakeholders include the Hawaii Coalition Against Sexual Assault, Hawaii Youth Services Network, the State Department of Education - School-Based Behavioral Health, Children's Justice Center and First Circuit Court, Injury Prevention Advisory Committee (IPAC), and Maui County Domestic Violence Task Force. FSVPS staff also continued to strengthen partnerships through the Early Childhood Action Strategy teams by identifying the relevance of CAN for the other teams (e.g., healthy and welcome births, on-track health and development, and access to needed programs and services).

Among stakeholders, there is a growing awareness of the co-occurrence of child maltreatment and other forms of

violence. Research suggests that 30 to 60 percent of the families where either domestic violence or child maltreatment is identified, it is likely that both forms of abuse exist. In addition, children can suffer from a range of emotional, psychological, and behavioral problems when witnessing or being exposed to violence in the home, even if they are not the direct victim. As a result of this identified need, training and technical assistance has focused on topics such as the short- and long-term impacts of children exposed to violence, adverse childhood experiences (ACEs), protective factors, and promotion of safe, healthy, and respectful relationships. Specifically, the FSVPS sponsored trainings addressing sex trafficking, integrating ACEs research, violence among at-risk populations including the LGBT community, cyber-sexual exploitation of minors, and the Period of Purple Crying. Trainings have expanded the community's understanding of violence, helped inform providers about best practices, and facilitated systems coordination.

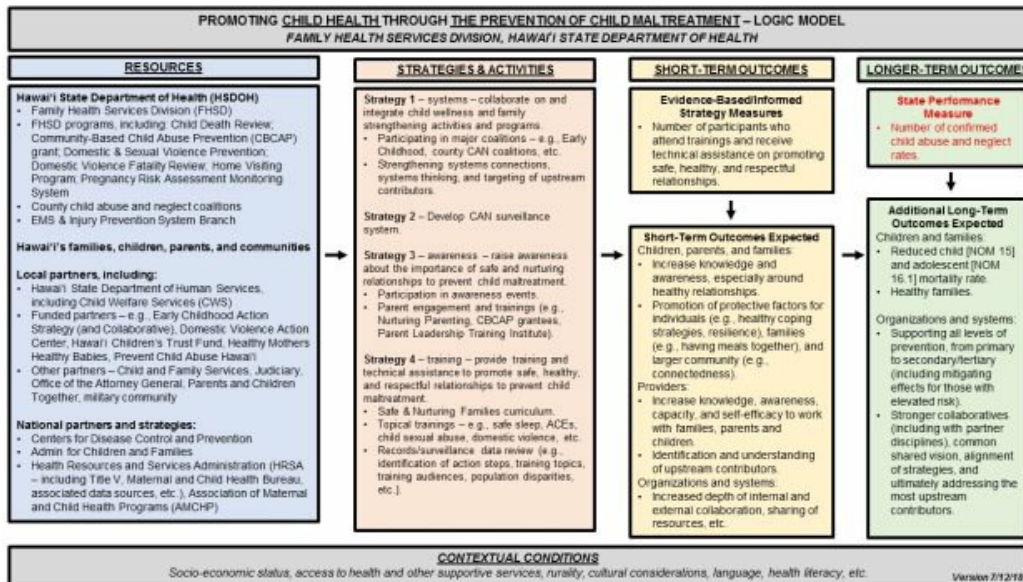
The Sexual Violence Prevention program sponsored several trainings from Futures Without Violence *Coaching Boys into Men* (CBIM) curriculum which provides high school athletic coaches with resources to promote respectful behavior among players and help prevent relationship abuse, harassment, and sexual assault. The CBIM curriculum consists of a series of coach-to-athlete trainings that illustrate ways to model respect and promote healthy relationships. The Centers for Disease Control and Prevention recognizes CBIM as an effective and promising evidence-based prevention program. As discussed, CAN prevention requires a long-range view, particularly for primary prevention. By learning about healthy relationships at a young age, these boys will carry forward the learned skills and behaviors into their own families and communities.

Several training activities were conducted specifically for parents and other caregivers. These were: 1) The evidence-based *Nurturing Parenting* curriculum that expands parent knowledge on child development and supporting the social and emotional development of their children; 2) The Parent Leadership Training Institute that builds the advocacy, communication and leadership skills of parents to address areas of concern such as accessible child health services, the achievement gap, and neighborhood safety; and 3) Safe Sleep practices to reduce the risk of SIDS and other sleep-related infant deaths.

Review of Action Plan

In previous years, Hawaii's Title V child abuse and neglect prevention measure was National Performance Measure (NPM) 7. This measure was inactivated and converted to State Performance Measure (SPM) 4 – the rate of confirmed child abuse and neglect reports per 1,000 for children, with emphasis on children aged 0 to 5 years. NPM 7 was removed because it does not align with the strategies and activities currently employed by the Family Support and Violence Prevention programs to reduce CAN and domestic and sexual violence in the state, and therefore was not accurately capturing progress specific to CAN prevention.

The CAN logic model below describes an overview of current and proposed future activities.



Preventing child abuse and neglect cannot be addressed as a stand-alone public health concern. As depicted in the logic model, it is important to acknowledge and address contextual conditions that impact and influence CAN negatively or positively, in tandem with programs that specifically target violence prevention. Fortunately, CANP has a broad base of resources within the Family Health Services Division and other State Executive Departments, namely the Department of Human Services/Child Welfare Section, Judiciary, and Office of the Attorney General. Other critical local partners include funded programs (e.g., Healthy Mothers Healthy Babies, Prevent Child Abuse Hawaii), programs under Child and Family Services, and Parents and Children Together (PACT), and the military. National partners support CAN prevention in the islands with funding, technical assistance, and training, and they also serve as data sources.

Challenges, Barriers

There is one major challenge that impedes CAN prevention progress, including strengthening the coordination and collaboration within the DOH and with other state departments. Different grant-related mandates (e.g., funding requirements, timeframes and budget periods, use of different indicators or performance measures and data collection methods, etc.) pose a challenge to creating a truly statewide, cross-agency/sector CAN prevention.

Overall Impact

CAN prevention is a long-standing priority within child health, which receives a high level of public support in Hawaii. As a result of advocacy efforts, a number of important bills were passed by the 2018 Hawaii State Legislature supporting CAN prevention (currently awaiting Governor's signature). These include: extending the period during which a victim of child sex abuse may bring civil action (will apply retroactively to April 24, 2012); authorization to disclose information regarding confirmed cases of child abuse or neglect; support for survivors of domestic abuse to relocate and keep relocation and contact information confidential; and millions of dollars to address the homeless problem.

Specific to the DOH, the FSVPS houses CANP, DVP, SVP, and PSP under one Section within the Maternal and Child Health Branch. This infrastructure helps facilitate collaboration, leveraging of in-kind support and funds as appropriate, and coordination of program activities and plans for the coming year. The FSVPS also has well-established partnerships with other family-serving programs within FHSD including the Neighbor Island District Health Offices, Women, Infants and Children (WIC), the Children with Special Health Needs Branch (CSHNB), and

the Office of Primary Care and Rural Health. External to the FHSD, partners include the Development Disabilities Division, Child and Adolescent Mental Health Division, and the Statewide Council of Developmental Disabilities.

On the national level, 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 System Branch, which receives TA from both the CDC and the Child Safety Network.

Child Health - Application Year

For the Child Health domain, Hawaii selected 3 performance measures:

- NPM 6 Developmental Screening
- NPM 13.2 Oral Health
- SPM 4 Child Abuse and Neglect Prevention

Plans for future activities for the three measures are described below.

NPM-6: Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed screening tool

For the Child Health domain, Hawaii selected NPM 6 Developmental Screening based on the 5-year needs assessment. By July 2022 the state seeks to increase the number of children ages 9 through 35 months, receiving a developmental screening to 34.0%. Plans to address this objective and NPM are discussed below.

Work on the developmental screening 5-year strategies will continue. The focus for FY 2018 is to continue work with partners to implement the statewide system for developmental screening, referral, and services. 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. Community level initiatives and input will be used to refine statewide policies, procedures and guidelines.

More emphasis will be placed on family engagement and addressing vulnerable populations. Because of changes to the NSCH and the focus on infants and toddlers, Hawaii may focus its efforts around the birth – toddler (birth to 36 month) age range. This will be helpful to focus conversation around the earlier identification of children and referrals to EIS since it helps to promote children's optimal development.

Strategies and activities will focus on working with the statewide efforts focusing on children living in homelessness. Children who have multiple risk factors may be more susceptible to developmental delay. The Head Start Collaboration Office Director has created a Child Homelessness Action Team (CHAT) that will be meeting monthly to address the needs of young children living in homelessness. Hawaii's Title V representatives are a part of this team.

The Title V Screening Work Group will oversee implementation of Title V screening efforts as outlined in the new ESM 6.2: the Policy and Public Health Coordination Scale (PPHCS). The 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				

NPM 13.2 Percent of children, ages 1 through 17 who had a preventive dental visit in the past year.

For the Child Health domain, Hawaii selected NPM 13.2 children's oral health based on the 5-year needs assessment. By July 2022 the state seeks to increase the percent of children, ages 1 through 17 who had a preventive dental visit to 87.0%.

The current grant project period for the SOHP closes on August 30, 2018. The SOHP submitted a new grant application, in response to the CDC's notice of funding opportunity, for a competitive 5-year award. FHSD is

awaiting the announcement of the award sometime in late July 2018. If received, the Title V strategies will change substantially. The strategies include school-based dental sealant programs, community water fluoridation, oral health surveillance and medical dental integration project to establish a bi-directional referral system for adults with a chronic disease. The SOHP developed a work plan for each of the strategies to improve oral health outcomes for children and the population at large. Activities include:

- Partner with FQHCs/CHCs to increase the number of school-based dental sealant programs, using the West Hawaii Community Health Center pilot project as a model.
- Initiate a large-scale educational campaign to inform the public about the benefits of fluoride. Leverage the support of the Hawaii Coalition for Oral Health (HiCOH).
- Develop a multi-directional referral system that addresses the connection between oral health and chronic disease with an adult target population. Starting with tobacco cessation programs and dentists and adding in diabetes prevention, mental health, cardiovascular health, and other areas.

In FFY 2018 the three-year VDH project will be completed with a final evaluation and report. The evaluation will examine the sustainability of the VDH in the State of Hawaii, analyzing the financial feasibility, dental practice laws and policies addressing teledentistry, and the acceptability of this community-based delivery of care model by the State's oral health stakeholders.

Due to high demand for VDH services across the neighbor islands, DOH secured funding for a second teledentistry pilot project on the island of Maui. In addition to serving young children, a senior assisted living facility will be included based on Maui community input. The project will also include an oral health professional educational component in collaboration with the Maui Community College Dental Hygiene School.

Based on the CDC award and future VDH funding, the Title V strategies and ESMs will likely be revised next year.

SPM 4: Reduce the rate of confirmed child abuse and neglect cases per 1,000 for children

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

MCHB is an active participant in the Early Childhood Action Strategy Initiative a statewide public-private collaborative that recognizes the strength of communities, and works across sectors to increase the number of young children in Hawaii who are born healthy, developing on track, ready for school when they enter kindergarten, and proficient by the third grade. MCHB is represented on this initiative as the CAN Prevention and Sexual Violence Prevention Coordinators serve as co-leads of one of six teams, namely Team 2 - Safe and Nurturing Families. This team is developing a statewide Safe and Nurturing Families Framework to achieve long-term outcomes of decreasing the rates of family violence to support the healthy development of Hawaii's youngest children. The first phase of this work will involve a public awareness campaign to decrease child abuse and neglect and intimate partner violence in Hawaii. An important goal to embed concepts related to social issues in creative media products and strategies to develop effective communication outreach for long-term success and sustainability.

Two new efforts will be started to increase awareness of CAN in two special populations. These are families, and other caregivers of children with a disability, and incarcerated men and women with families. Research has shown that children with disabilities are at least three time more likely to be abused or neglected than their peers without disabilities. These children are also more likely to be seriously injured or harmed by maltreatment. The CAN prevention program will be conducting a statewide assessment to determine the current prevention services and resources available to special needs children and their families and the gaps in services and resources. The

assessment will also explore the need for specialized training to ensure these children have a safe and nurturing relationships at home and while in care.

Strategy 2: Community-based training and technical assistance promoting safe, healthy, and respectful relationships to prevent child abuse and neglect.

ACES and resilience trainings will continue to be the major activity occurring during this timeframe. Trainings will include targeted audiences (“first responders”), community-based organizations, state Departments of Education, Human Services, and others as identified or via requests.

A pilot project will be implemented on Hawaii County to support parents who are incarcerated. The project will involve parenting classes to ease transition back to their families when released. The CAN prevention program will partner with the “Going Home Consortia” that focuses on transition of incarcerated adults back into the community to identify and provide parenting training and identify possible concrete supports for the parents and children.

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

The three violence programs are in the early stages of developing a “dashboard” that will include infographics, data charts/tables, and text presenting information about the importance of resilience as a mitigating factor for children who experience one or more adverse childhood experiences (ACEs). The dashboard is envisioned to present data on the status of resilience of children in Hawaii using data from the National Survey of Child Health as well as a description and presentation what the FSVP and Home Visiting programs are doing to build resilience in the islands for children 0-8 years of age. The initial audience for the dashboard will be the FSVP and Home Visiting program, however the vision is to expand the use of the dashboard to bring in other MCHB, CSHNB, and eventually Division level programs. The eventual goal is create and have on-line an interactive dashboard available to the public.

Strategy 4: Develop child abuse and neglect (CAN) surveillance system

A new important initiative will be creating a CAN data surveillance plan. Hawaii has no statewide child maltreatment surveillance system. While multiple sectors are collecting such data, there is no common ways the data are defined, collected, analyzed, used, and shared. The goal is to apply a systems approach to support data collection and sharing.

New State Performance Measure - SPM 4: Rate of confirmed child abuse and neglect cases per 1,000 for children with special attention on children 0 to 5 years.

Strategy 1: Collaborate on and integrate child wellness and family strengthening activities across programs.

Strategy 1 will continue through the tremendous work done by key CAN coalitions such as the neighbor island child abuse and neglect prevention coalitions, Team 2 of the Early Childhood Action Strategy (ECAS), and the Hawaii Children’s Trust Fund (HCTF). Maui County’s CAN coalition, the Ho’oikaika Partnership, is composed of 60 Maui County agencies and concerned individuals that all have a common interest in the prevention of child abuse and neglect. The Partners are identifying and addressing system gaps, as well as continuously expanding knowledge and use of protective factors to reduce the incidence of child abuse and neglect. The ECAS partnership involves over 80 private and public partners working across six critical focus areas to build a comprehensive and integrated early childhood system. The DOH Sexual Violence Prevention Program and CAN Prevention Program Coordinators

serve as Co-Leads of the Safe and Nurturing Team, which is currently focusing on a five-year messaging campaign to prevent child abuse and neglect.

DOH is currently in discussions with the Hawaii State Department of Human Services to explore leveraging of funding such as State General Funds, Family First, Medicaid, and Temporary Assistance for Needy Families, and Private Health Insurers. Together, both Departments continue to brainstorm and develop ideas on joint efforts to expand home visiting services statewide, including the feasibility of adding the Nurse Family Partnership as an additional evidence-based home visiting model.

Strategy 2: Develop a child abuse and neglect (CAN) surveillance system.

While many have a part to play, state health departments are well positioned to advance and provide leadership for child maltreatment prevention efforts. State health departments can provide expertise in assessment and surveillance of public health problems. Hawaii has no statewide child maltreatment surveillance system. While multiple sectors are collecting such data, there is no common way that data are defined, collected, analyzed, used, and shared. Because of this critical missing piece in the prevention of CAN, a new important initiative will be to develop a CAN surveillance plan. The goal is to apply a systems approach to support data collection and sharing.

Building a surveillance system in general is a complex and long-term endeavor. Guides such as the CDC Child Maltreatment Surveillance System: Uniform Definitions for Public Health and Recommended Data Elements will be reviewed for application. In addition, technical assistance will be requested from the CBCAP contractor, Family Resource Information, Education, and Network Development Service (FRIENDS), and other federal and state resources.

The three violence programs envision a “dashboard” as one future application of surveillance data. The dashboard would include infographics, data charts/tables, and text presenting information about the importance of resilience as a mitigating factor for children who experience one or more adverse childhood experiences (ACEs). The dashboard is envisioned to present data on the status of resilience of children in Hawaii, as well as descriptions of what programs are doing to build resilience in children. The initial audience for the dashboard will be the FSVPS. However, the vision is to expand use of the dashboard to other MCHB, CSHNB, and eventually Division-level programs, and eventually create an online interactive dashboard available to the public.

Strategy 3: Raise awareness about the importance of safe and nurturing relationships to prevent child abuse and neglect.

Strategy 3 will continue to be met by supporting year-round public events such as the designated Child Abuse and Neglect Prevention month in April and monthly family reading times at public libraries. Activities are conducted in partnership with a range of community-based organizations noted under the Resources column of the logic model. Such public events are key vehicles to increasing awareness and providing a way to nurture the parent-child relationship. Parent awareness and knowledge-building is accomplished through this targeted engagement and training opportunities.

DOH FSVPS is an active participant in the Early Childhood Action Strategy Initiative, a statewide public-private collaborative that recognizes the strength of communities, and works across sectors to increase the number of young children in Hawaii who are born healthy, developing on track, ready for school when they enter kindergarten, and proficient by the third grade. The FSVPS CAN Prevention and Sexual Violence Prevention Coordinators serve as co-leads of one of six teams (Team 2 - Safe and Nurturing Families). This team is developing a statewide Safe and Nurturing Families Framework to decrease the rates of family violence to support the healthy development of Hawaii’s youngest children. The first phase of this work will involve a public awareness campaign to decrease child

abuse and neglect and intimate partner violence in Hawaii. An important goal of this process is to embed concepts related to social issues in creative media products and strategies, to develop effective communication outreach for long-term success and sustainability.

A new effort will be started to increase awareness of CAN prevention among children and young adults with special needs. Research has shown that children with disabilities are at least three times more likely to be abused or neglected than their peers without disabilities. These children are also more likely to be seriously injured or harmed by maltreatment. The CAN prevention program will be conducting a statewide assessment to determine the current prevention services and resources available to special needs children and their families, as well as the gaps in services and resources. The assessment will also explore the need for specialized training to ensure these children have a safe and nurturing relationships at home and while in care.

Strategy 4: Provide community-based training and technical assistance promoting safe, healthy, and respectful relationships to prevent child abuse and neglect.

Strategy 4 will continue to be addressed through training events that serve to expand awareness and provide tools to support prevention within a specific population or context. Trainings and technical assistance events will continue to employ a summary and evaluation component to understand the composition of the training audience, the population served by attendees, and overall training effectiveness. Attendees are also queried regarding unmet or new training needs.

Future training topics related to child maltreatment issues include safe sleep, ACEs, domestic violence, sex trafficking, and abuse of persons identifying as lesbian, gay, bisexual, transgendered, and queer or questioning (LGBTQ). ACEs and resilience trainings will be the major training focus during this timeframe. Trainings will target audiences such as first responders, community-based organizations, the state Departments of Education and Human Services, and others as identified or via requests. The HVP will continue to provide quarterly trainings to their contracted statewide service providers. FSVPS staff and other agency partners will continue to be invited. Finally, results of the assessment pertaining to special needs children may demonstrate other training needs.

Title V Child Health Programs

Other Child Health programs administered by Hawaii Title V that were not discussed in the performance measure narratives.

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

Childhood Lead Poisoning Prevention: Hawaii received funding from Centers for Disease Control and Prevention (CDC) to reduce lead exposure and lead poisoning of children from birth through five years of age.

Children and Youth with Special Health Needs: provides assistance with service coordination, social work, nutrition, and other services for children with special health care needs age 0-21 years with chronic medical conditions. It serves children who have or may have long-term or chronic health conditions that require specialized medical care and their families.

Early Intervention Section (EIS) is a federal and state-mandated program that provides services to support the development of infant and toddlers from birth to three years of age.

Hi'ilei Hawaii: is a free resource for parents of children from birth to 5 years old. Hi'ilei provides developmental

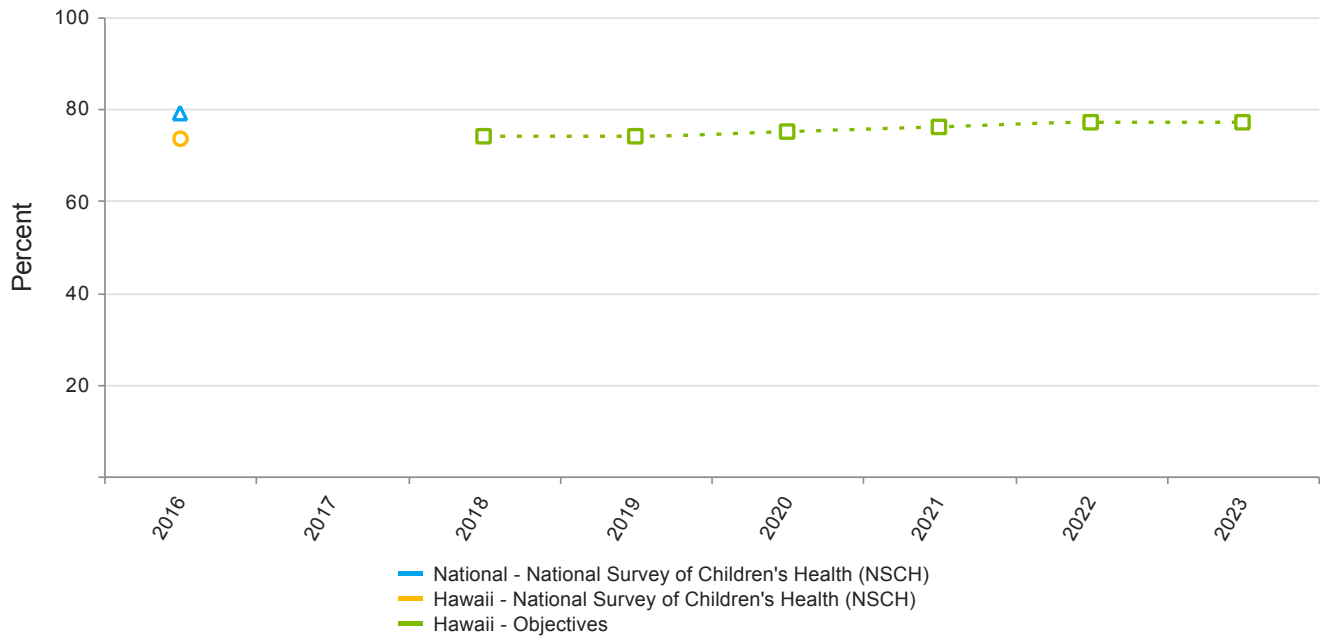
screening and information for families who are interested in supporting their young child to reach optimal development.

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-2016	33.7	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2014_2016	10.9	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2014_2016	13.0	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016	38.4 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	91.7 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016	11.0 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	10.3 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2015	12.9 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2016_2017	60.6 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2016	71.7 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2016	58.3 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2016	82.2 %	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-2016	75.9 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	19.2	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	2017
Annual Objective		
Annual Indicator		73.5
Numerator		67,325
Denominator		91,592
Data Source		NSCH
Data Source Year		2016

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	74.0	74.0	75.0	76.0	77.0	77.0

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
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State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator		
Numerator	13	16
Denominator	51	51
Data Source	ART and Science Workgroup	ART and Science Workgroup
Data Source Year	2016 PRog	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	16.0	19.0	22.0	25.0	30.0	35.0

State Action Plan Table

State Action Plan Table (Hawaii) - Adolescent Health - Entry 1

Priority Need

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

NPM

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

Objectives

By July 2020, increase the percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year to 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.

Youth and Family Engagement/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, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Adolescent Health - Annual Report

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

Introduction: Adolescent Wellness Visits (AWV)

For the Adolescent Health domain, Hawaii selected NPM 10 preventive wellness visits based on the results of the 5-year needs assessment. Data from the 2016 National Survey on Child Health show the estimate for Hawaii (73.5%) was similar to the national estimate of 79.0%. With this baseline data, the state objective for 2022 was set at 77% reflecting a 5% improvement over 5 years.

Key disparities exist for access to preventive care in Hawaii for adolescents. Rates for parents with less education, non-English speaking households, and those residing in rural areas have significantly lower rates.

NSCH shows that parents who were college graduates were more likely to have their adolescents seen for a preventive visit (84.7%) compared to those who had some college (66.3%) or were high school graduates (53.2%). Those with less than high school graduates were not reported due to small numbers. Similarly, those who lived in households at $\geq 400\%$ FPL were more likely to have had a preventive visit (86.0%) compared to those at 200-399% FPL (68.6%) and below 100%FPL (58.6%). Those where a non-English language was spoken at home had lower estimates (53.3%) of an adolescent preventive medical visit compared to English speaking households (76.0%).

The 2017 Youth Risk Behavior Survey data showed 47.9% of middle school aged adolescents and 65.9% of the high school teens reported seeing a doctor for a check-up or preventive physical exam. This is a slight increase since 2015: (2% for middle school and 4% for high school teens). Neighbor island disparities remain. Kauai County reported the lowest percentages of adolescent wellness care visits among middle and high school adolescents followed by Maui County and Hawaii County.

Additionally, Hawaii EPSDT data shows a dramatic decrease of health visits as children reach adolescence.

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, AWVs 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.

Surveys reviewed as part of the Title V needs assessment indicated 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.

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.

The Adolescent Health Unit (AHU) is the lead for the AWW measure and drives the activities of the Adolescent Health Steering Committee (AHSC). THE AHSC includes members from FHSD/Maternal and Child Health Branch (MCHB) teen pregnancy prevention program (funded by the Personal Responsibility Education Program grant) family planning (Title X funding), domestic violence and sexual assault prevention units (Centers for Disease Control and Prevention grants), and Hilopa'a F2FHIC who consult with Partners in Quality Health (management service organization (MSO) for leading Independent Physician Association in Hawaii), and American Academy of Pediatrics Medical Home Task Force.

Coordination with NPM 12: Transition to Adult Health Care

Hawaii elected to continue work on the state priority to improve the percentage of youth with special health care needs (YSHCN) ages 14-21 years to make the transition to adult care. The national performance measure for transition services addresses both youth with and without special needs. The Title V Adolescent Health program manager is coordinating efforts with the CSHN program to address both adolescent health performance measures.

Strategies to address the objective and NPM for adolescent preventive visits are discussed below.

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

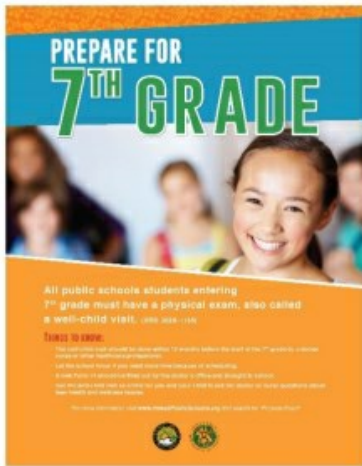
The AHSC provides, training, support, and user friendly materials to primary care providers to ensure these AWW are teen-centered, comprehensive and meet the "Bright Futures" guidelines. AHSC is comprised of key organizations committed to this purpose and participated in developing strategies and driving implementation activities. 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 delivered the education/training "science" to health providers and consumers on adolescent health.

Partnering with the University of Hawaii, a literature review was conducted on barriers to AWW and a search conducted for adolescent resource toolkits. The two key barriers are an adolescent's capacity to make their own doctor appointments and accessing health information when it's needed.

Through the national network of state adolescent health coordinators, Hawaii received the first release of New Mexico (NM) Department of Health's adolescent health toolkit for health care providers. With permission from NM and assistance from university practicum interns, the ART's content and online features served as the foundation for Hawaii's ART for providers.

Title V is an active participant in the Hawaii Health Survey committee which consists of the Department of Education, the University of Hawaii, Office of Hawaiian Affairs and DOH representatives, and 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 also an important measure for AWW from the perspective of teens. The larger sample size also allows for more detailed analysis on demographics and in respect to other risk/protective behaviors.

Strategy 2: Youth & 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.



A major public messaging campaign to youth and families was launched in 2017 to promote AWW for public school entry into the 7th grade. The 2016 Legislature passed Act 185 which requires all youth entering the 7th grade to have a physical examination. The DOH's Chronic Disease and Health Promotion Division (CDHPD) helped lead the effort to pass Act 185 and convened a broad coalition of private-public partners to assure successful implementation including the Department of Education (DOE), the Hawaii Primary Care Association, the Hawaii Medical Services Association, and the American Academy of Pediatrics Hawaii Chapter. The DOE and DOH developed public service announcements to parents and youth; standard messaging for parents and providers, distributed copies of the required doctor's exam forms to primary care providers statewide, and conducted trainings to assure providers understood the procedures needed to adequately complete the required forms. CDHPD reported that of the 12,613 public school

teens entering the 7th grade, 47.8% (6,013) met the physical exam requirement and 52.2% did not. CDHPD will look at follow-up for the next year.

The AHSC added information on Act 185 and recent changes to the 'age of consent' laws to the ART. Act 181 which allows adolescent's the right to consent to their own mental health treatment and counseling services was passed in 2016. 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.

Based on comments received from teens, the AHSC decided to create a resource toolkit for teens, the Teen Adolescent Resource Toolkit (TART). The TART is intended to engage and inform adolescents and families on self-care and accessing preventive and intervention services independently. The TART will include a prominent section on consent policies for teens to understand with rights to privacy and ability to access care. A preliminary draft of the TART was shared with a focus group of teens. Based on the input, infographs, memes and websites will be used and will help teens learn to make an appointment for: a chronic condition check, request a referral to a dermatologist, psychologist or other specialist, when needed. Input on the TART content and design was collected via participants in the Title V teen pregnancy prevention grants.

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

The two primary products under development are the Provider Adolescent Resource Toolkit (ART) and the new Teen Adolescent Resource Toolkit (TART). The information in the ART is geared to assist providers to maximize the AWW and build rapport with their patients. The TART aims to inform teens and their families and will include: the benefits of an AWW, age of consent and other access to care laws pertinent to adolescents, local and federal websites and apps that have been vetted by the medical community.

The Title V AHU is the Teen ART (TART) lead, a new project born from input provided by adolescents which were asked to comment on the content of the ART. Input from F2FHIC, youth participants and young adults has been key to identifying the baseline content and design for the community of service providers and the target population, the

adolescents.

For the ART, major work was completed on the following training modules: Screening, Brief Intervention and Referral to Treatment (SBIRT), behavioral health, substance use, sexual activity training and the transition to adulthood curriculum series project. The primary care substance use training materials were developed and tested with providers by F2FHIC. The SBIRT, an evidence-based practice, can be integrated into an AWW. Pediatricians on Oahu and Hawaii Island received SBIRT training during the first quarter of 2017.

The Hawaii Maternal and Infant Health Collaborative (HMIHC) partnership with the State Medicaid office resulted in a new Medicaid reimbursement policy for prenatal SBIRT. Any obstetrician contracted by Medicaid may bill for SBIRT once the provider completes the F2FHIC training. Thus, F2FHIC created an adolescent SBIRT to integrate into their training with prenatal care providers who also work with teens.

Currently, the ART is a computer-based resource; however, providers have indicated that a hard copy resource manual that includes brochures/handouts for clients would also be useful. F2FHIC also completed teen-centered content modules promoting “Bright Futures” on: substance use, behavioral health, sexual activity and transition to adulthood that will be added to the hard copy resource manual. Homelife, healthy eating, repurposing the sports physical visit, and delivering teen-centered care topics will be included in the future. The AHSC is seeking funding and a vendor to continue work on this project.



Through the work of HMIHC, the AHSC learned about the *SafeSex808* online resources aimed at teens and young adults to reduce the cases of sexually transmitted disease and unintended pregnancies. Spearheaded by the University of Hawaii John A. Burns School of Medicine (JABSOM), safesex808.org is an interactive reproductive health website, complete with an on-line “talk to a nurse” feature. AHSC integrated information on the resource into the ART/TART and will help to

publicize the local website to service providers, teens and young adults, and their families.

The AHU will work with the DOH family planning section to train adolescent service providers and possibly parents to utilize One Key Question® to start a preventive health conversation with youth. The question: “Would you like to become a parent in the next year?” would be asked and regardless of the answer, the recommendation would be to have an AWW if they did not have one in the last twelve months.

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

To date, compilation of state laws and policies related to adolescent health care including confidentiality, medical record documentation consent/assent information and accessing reproductive health services have been integrated into the provider focused ART. Hawaii based referral algorithms for behavioral health, substance use, sexual activity, and transition to adulthood are in development under Hilopa’a F2FHIC’s leadership.

F2FHIC continued to provide interactive lunch hour webinars to primary care providers and their staff. Hilopa’a also conducts real-time surveys to collect provider input and feedback during these webinars or during meetings. The AHSC participates in both venues and has acquired baseline knowledge and skills to partner with providers. Information collected include provider opinions regarding replacing sports physicals with AWWs and the challenges implementing confidentiality policies into their practices.

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.”

The measure is designed to track progress on the preventive nature of the ART and “Science” or health provider training modules, in areas that are assessed during the AWW. The protective factor is recognizing the preventive or interventive opportunity that may be affecting an adolescent’s wellness trajectory and addressing it appropriately. 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:

Provider Adolescent Resource Toolkit (ART) Strategy 3

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) for Providers Strategy 4

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 to Providers Strategy 4

12. Convene AHSC regularly 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.

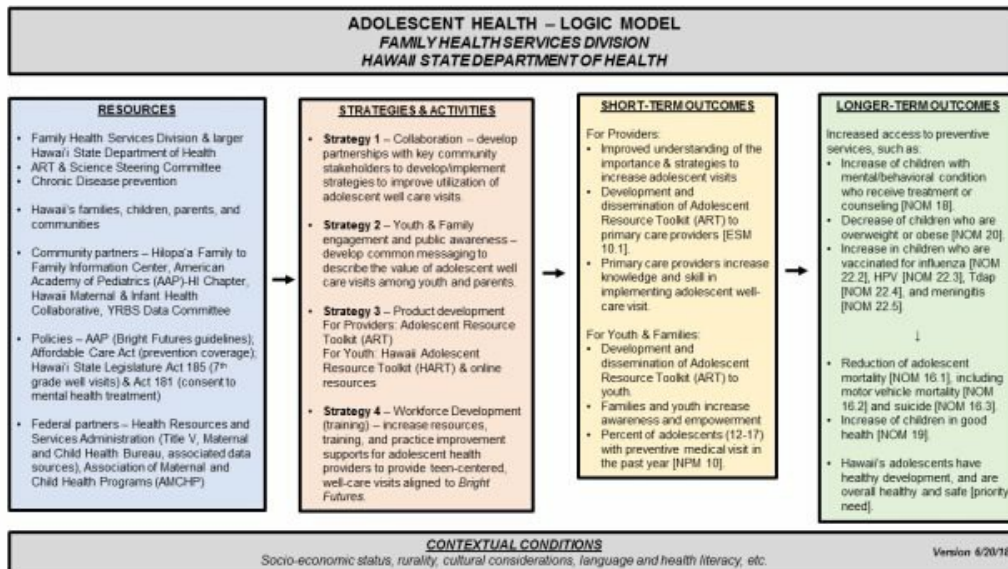
Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 51. Scoring is completed by Title V staff, with input from ART & Science Workgroup. The data collection form is attached as a supporting document.

For FFY 2017 the degree to which the Adolescent Resource Toolkit (ART) was completed and continuing education series conducted (ESM 10.1) is measured at 16 out of 51.

Review of the Action Plan

A logic model was developed for NPM 10 to review the alignment between the strategies, activities, measures and desired outcomes. By working on these three strategy areas, Hawaii plans to increase the percentage of adolescents who had a preventive medical visit. The four 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, and Medical Home Resources Guide for Children with Special Health Care Needs, a hallmark product of Hawaii services. The strategies have been modified to reflect Hawaii's expanded focus to work with adolescents and their families.



Challenges, Barriers

Creating a culture shift among health plans, providers, parents, and youth to value and prioritize AWWs 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 AWW.

Many families are unaware of their health insurance coverage for the AWW and appointments are made for adolescents only when illness or physical ailments are verbalized. Moving forward, families and adolescents themselves should know the many benefits of an AWW and how to access and maximize the AWW.

New players in the health care market like 'minute clinics' and urgent care centers also pose new challenges to AWW. Busy families utilize these convenient community based options as a primary source of care which can undermine the more comprehensive AWW provided by the medical home.

Due to other priorities (including statewide SBIRT training), participation by the lead drivers for the ART development and workforce trainings (Hilopa'a F2FHIC and AAP) have not been able to attend AHSC meetings or commit to the project efforts. Thus, progress in this area is likely to wane in FY 2018. Strategies will be reassessed based on partner availability and resources.

Overall Impact

The passage of Act 185 which requires all youth entering the 7th grade to have a physical examination comes at an opportune time to help rollout provider resources to address the unique needs of adolescents during wellness visits. Data collected by the DOH public health offices in this inaugural year, showed that 47.8 percent of Hawaii's fifty-two

public middle school adolescents that entered the 7th grade had received physical examinations. Of the fifty-two schools, there was a single middle school (Wheeler Middle School, Central Oahu) where all 263 students received physicals. This information will be used to maximize workshops and informational meetings in the lower complying communities prior to the new school year and will also help to inform the AWV strategies.

The provider webinar trainings have been well-received to date and there is greater appreciation for importance of a comprehensive AWV. F2FHIC and the AAP-Hawaii Chapter, is largely responsible for conducting the bi-monthly webinars for providers that address youth centered issues. The F2FHIC and AAP will remain critical partners to successfully identify and implement activities for the provider community to help promote AWV under the Affordable Care Act.

Adolescent Health - Application Year

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



Title V will engage youth groups and families when possible to inform our work as we develop the provider Adolescent Resource Toolkit (ART) and the Teen Adolescent Resource Toolkit (TART), 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 AHU 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 needed to make an appointment. The team will also continue to explore ways to remove barriers that would prevent adolescents and their families from seeking preventive care visits.

Work on the development of the ART for health care providers building teen capacity to access health care services, and messaging to teens, parents and service providers on the value of an AWW, will continue.

Identifying new partnerships will also continue. The DOH Alcohol Drug Abuse Division and Developmental Disabilities Division have been identified as partners to review, test and disseminate information using direct service staff when the TART is developed and prepared for release.

Specific activities planned for this fiscal year include:

- Identify funding and vendor to redesign the ART into a resource manual with brochures/information for youth/families.
- Revisit the implementation plan with the AHSC.
- Assess parent and family awareness regarding adolescent preventive health care and barriers to accessing care to inform strategy development and the development of the Teen Adolescent Resource Toolkit (TART).
- Document complete inventory and clarify 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. Introduce the "safesex808" website developed by the University of Hawaii's Women's Resource Center as the primary sexual health resource for providers.

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.

Title V Adolescent Health Programs

Adolescent Health programs administered by the Hawaii Title V program include:

Adolescent Wellness: spans across the physical, mental and social emotional aspects of adolescents and young adults 10 to 24 years of age. Concentration on sexual health, positive youth development and transitioning into adulthood.

Personal Responsibility Education Program: The purpose of the grant is to fund evidence based programs that

educate youth on abstinence and contraception for the prevention of pregnancy, sexually transmitted infections, and HIV/AIDS, and incorporate education in preparation for the transition to adulthood. This program targets services to high-risk, vulnerable and culturally underrepresented youth populations between the ages of 10 and 19. In Hawaii, funds are used to allow the Youth Challenge Academy, which serves at-risk youth, to implement the Teen Outreach program curriculum on Oahu and Hawaii island.

Child Abuse and Neglect, Domestic and Sexual Violence Prevention: committed to the primary prevention of all forms of violence and stopping violence before it begins so that all people, families, and communities are safe, healthy, and free of violence. The Family Strengthening & Violence Prevention Unit provides programs statewide for the prevention of child abuse and neglect, sexual violence and domestic violence and support for parents. Supports provision of education targeted a teens to prevent sexual violence.

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

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

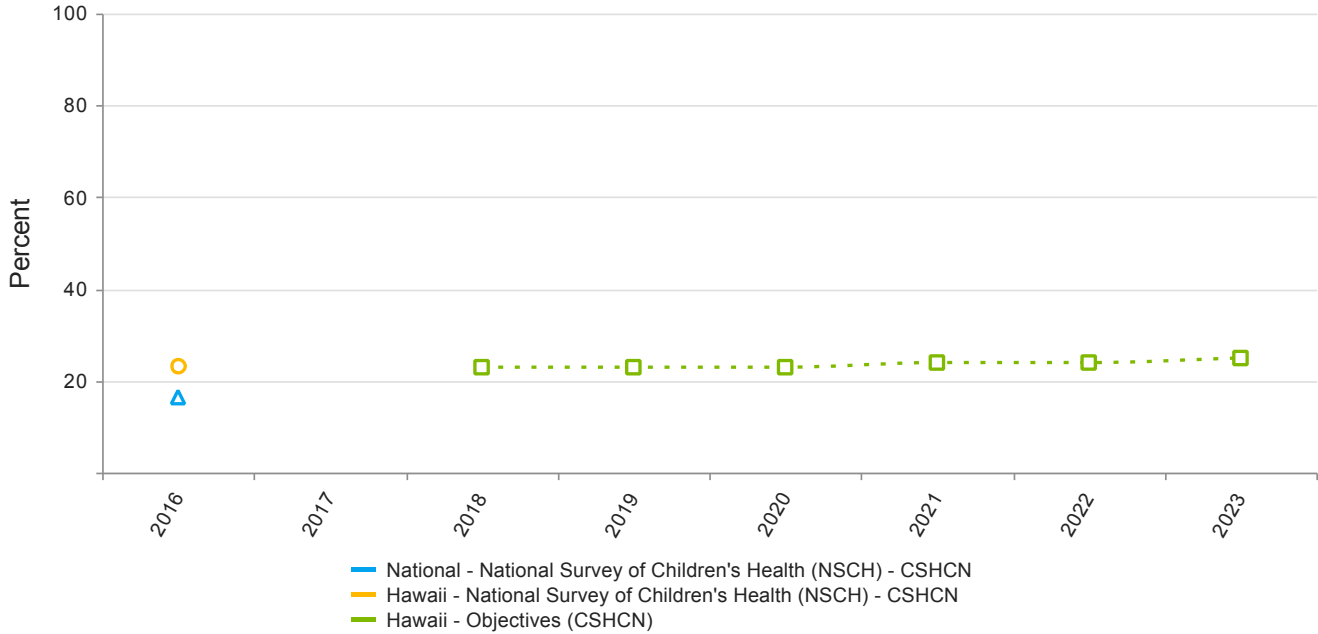
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016	16.7 %	NPM 12

National Performance Measures

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Baseline Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	2017
Annual Objective		
Annual Indicator		23.3
Numerator		4,235
Denominator		18,144
Data Source		NSCH-CSHCN
Data Source Year		2016

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	23.0	23.0	23.0	24.0	24.0	25.0

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
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State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator		
Numerator	12	13
Denominator	33	33
Data Source	Title V Transition Workgroup	Title V Transition Workgroup
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	17.0	21.0	25.0	27.0	27.0	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

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

By July 2020, increase the percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care to 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), ages 0 through 17, who receive care in a well-functioning system

NPM 12-Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Introduction

For the Children with Special Health Care Needs (CSHCN) population domain, Hawaii selected NPM 10 transition to adult health care based on the results of the 5-year needs assessment. By July 2022, the state seeks to increase the percent of youth with (and without) special health care needs who received transition services to 24.5%. In 2016, new baseline data from the National Survey of Children's Health (NSCH) showed that the estimate for Hawaii's youth with special health care needs (YSHCN) (23.3%) was similar to the national estimate of 16.5% (no significant difference). The estimates for youth *without* special health care needs were also similar in Hawaii (10.4%) and the nation (14.2%) (no significant difference). The objectives reflect a 5% improvement over 5 years. There were no significant differences in reported subgroups by household income poverty level, nativity, race/ethnicity, sex, and household structure based on the single year 2016 data.

The focus on the transition of CSHCN to adult health care is a continuing priority for Hawaii from the previous needs assessment led by the Children and Youth with Special Health Needs Section (CYSHNS) within the Title V Children with Special Health Needs Branch (CSHNB). The new guidance expands the focus on transition planning to youth *without* special health care needs. Thus, CYSHNS is collaborating with the Title V Adolescent Health program to integrate transition planning into efforts to promote adolescent wellness visits.

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. Compared to those without special health care needs, YSHCN are less likely to complete high school, attend college, or be employed.

Professional and state/community agencies and organizations in Hawaii support and are actively working to promote transition to adult life. The American Academy of Pediatrics (AAP)-Hawaii Chapter priorities include transition of adolescents to adult care with a focus on youth with special health care needs. The Hilopa'a Family to Family Health Information Center (F2FHIC) trains medical providers, other professionals, and families statewide in transition planning. Also, a statewide network of youth agencies and programs, including the state Department of Education (DOE), collaborates on annual transition events held throughout the year. Starting in ninth grade, DOE students begin their individual Personal/Transition Plans that chart their course from high school to post-secondary and/or career venues. Health is not specifically mentioned, but it can be included as part of necessary supports to attain education or training goals.

Strategies to address this objective and NPM are discussed below.

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

Policy Development

CYSHNS transition efforts are guided by the *Got Transition's Six Core Elements of Health Care Transition 2.0* (<http://www.gottransition.org/providers/index.cfm>). The Core Elements are being integrated into the CYSHNS service protocols to support CYSHNS youth and their families in preparing for transition to adult health care. The first activity required developing a policy statement that describes the program's approach to transition. The policy was developed with input from youth, families, and providers and was approved in March 2017. The policy 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.”

The policy is on CSHNB website (<http://health.hawaii.gov/cshcn/home/communitypage/>) and is being integrated into the Children with Special Health Needs (CSHN) Program brochure that is disseminated among providers and consumers.

Education of Staff

CYSHNS is educating all staff about the transition approach, 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. CYSHNS focused on developing a protocol for obtaining consent/assent from youth as part of the transition planning process. A “*Step Up! Transition to Adult Health Care!*” meeting was held in June 2017 with CYSHNS including Title V nurse managers from Hawaii island, Kauai, and Oahu; Hilopa’a F2FHIC; and a youth representative and her parent. The meeting identified touchpoints in time for youth/families where consent/assent can be obtained. The meeting was facilitated by the Hilopa’a F2FHIC Director.

Tracking and Monitoring

As part of this activity, CYSHNS established criteria for tracking youth to assure transition planning was occurring as part of service coordination services: For age 0-12 years, health-related habits, knowledge, and skills are tracked. For age 12-21, transition planning, assessment, and goals are tracked. For age 18-21 years, adult health care provider and health insurance are tracked. At discharge from CYSHNS services, future health care services are tracked. A draft data collection form 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.

With the criteria established, the CYSHNS client data system needed to include documentation of this information. The system, a DOS database, has been in place for the last 20+ years. Work began with a software consultant to upgrade the system from DOS to a Microsoft Access database system. The program began the database transition in April 2018.

Transition Readiness

At least annually staff are asked to assess transition readiness with youth and their parents/caregivers, beginning at age 12, to identify needs related to the youth managing his/her health care. With input from youth and families, a pre-transition handout for children under age 12 years was drafted. The handout promotes responsibility and self-advocacy in the areas of: health, education and work, and independence. The handout also gives youth and their families activities to work on together. The handout reminds families to allow youth to practice simple life skills, so that youth may gain the confidence and “know-how” to tackle more sophisticated responsibilities as they mature.

The handout was developed by CYSHNS staff through participation in the DOH Developmental Disabilities Division (DDD) Community of Practice (CoP) meetings and trainings on the Fundamentals of LifeCourse Framework. The CoP purpose is to create policies, practices, and systems to better assist and support families that include a member with intellectual and developmental disabilities across the lifespan. After numerous edits and design improvements, the Transition Readiness Assessment is being used by CYSHNS staff with their clients but is still a work in progress.

Transition Planning

At least annually, staff should assure the plan of care is updated in partnership with youth and their families, including

readiness assessment findings, goals, and prioritized actions. These discussions focus on adult health care providers, health insurance, and personal responsibility. Transition planning has also been included in other CSHN programs/activities: Kapiolani Cleft and Craniofacial Clinics, Hawaii Community Genetics Clinic, the Early Language Working Group, and neighbor island cardiac/neurology/nutrition clinics.

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. Based on client and staff feedback, a major format change was made to the transition planning template. The new streamlined template is being used with youth and families and was just revised.

Transfer of Care/Transition Completion

Staff will assist the youth and parent/caregiver for transfer to an adult health care provider and planning for health insurance coverage as an adult. Efforts are underway to study current practices and develop a more standardized approach to transition planning. Staff discuss transition with clients, but documentation retrieval remains a challenge.

Staff will provide referrals to adult service agencies. CYSHNS has not yet developed procedures for these referrals, but continues to participate in the state “No Wrong Door” (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 an integrated person-centered system of long-term services and supports for individuals of all ages, all disabilities and all payers. This NWD system will help youth/families gain access to service providers and will help service providers to better assist individuals.

The most challenging activity is Transition Completion. Staff are required to contact the youth and parent/caregiver, when CYSHNS services end, to confirm having an adult health care provider and health insurance coverage, or provide further assistance. CYSHNS is exploring ways to do this in a feasible way.

The ESM 12.1 corresponds to the CYSHNS work under Strategy 1. The measure is a scale of measuring progress to complete 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 Hilopa’a F2FHIC.

For FFY 2017, the degree to which the Title V CYSHNS promotes and/or facilitates transition to adult health care for YSHCN is measured at 13 out of 33 (a 39% completion rate), exceeding the annual objective of 10. This is substantial progress over the 2016 indicator of 4 (a 12% completion rate).

In 2017, 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.

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 guidance and input with local stakeholders. The 2020 Federal Youth Transition Plan and other reports recommend close collaboration among providers working with transitioning youth and supporting quality professional development for staff. The Centers for Medicare &

Medicaid Services (CMS) 2014 report on *Paving the Road to Good Health* recommended developing partnerships among key stakeholders and creating adolescent-friendly material.

Educational/Awareness Events

CYSHNS continues multiple collaborations with stakeholders, including youth and family members, to conduct educational transition presentations and events annually. Most events are held on state DOE high school campuses in each county. For Oahu, the event locations are rotated among the four school districts.

The Windward District hosted the *Footsteps to Transition Fair* in October 2017 at Windward Community College (WCC), a new venue and partner. WCC was a great location – well known, accessible, ample parking, with extensive space for display tables. The hope is that more community colleges will participate in transition events since families have requested more information on colleges and technical schools. The Hilopa‘a F2FHIC Director, Best Buddies Hawaii (BBH), and Self-Advocate Advisory Council (SAAC) presented on transition to adult life to youth, families, and state/community agencies. Over 40 agencies had display tables, with over 150 youth and their families attending. Honolulu Community College is an active partner since its disability specialist co-chaired the planning meetings in past years.

As an advisory board member, CYSHNS participates in Special Parent Information Network (SPIN) and its annual statewide conference. SPIN is a parent to parent organization in Hawaii that provides information, support and referral to parents of children and young adults with disabilities and the professionals who serve them. SPIN and its sponsors support families from the neighbor islands to attend this Oahu event. Roughly 65 vendors and over 400 family members participate in this conference with speakers, workshops, awards ceremony with fun activities, and respite services. The SPIN conference celebrated its 30th anniversary in 2018.

Other transition events include the Special Olympics, Malama da Mind, Kauai’s Legislative Forum, Kona’s Marshallese Day, Healthy From Head to Toe, You Can’t Have Inclusion Without Us, Parent Child Fair, and Keiki Steps. Transition issues were discussed with athletes, parents, and caregivers at the Healthy Hearing venue of the Hawaii Special Olympics 50th Annual State Summer Games in May 2018, for which the CYSHNS Audiologist was a co-director.

CYSHNS provided a presentation on “Support for Children & Youth Transitioning to Adult Health Care” in March 2017 at a meeting sponsored by the State Medicaid program. The meeting was for the Medicaid health plan mid-level managers to be more aware of current supports for children transitioning to adulthood.

The CYSHNS Public Health Nutritionist provided an inservice for nutritionists at a local hospital, focusing on adults with inborn errors of metabolism who have a higher probability of admission; the inservice contributes toward increasing access to adult specialty services. CYSHNS also arranged educational opportunities for youths with inborn errors of metabolism to learn how to cook a variety of low protein foods and to navigate insurance issues regarding needed supplies; this contributes to youths being better prepared for adult life. -

Partnerships & Networking

CYSHNS is connected to a broad network of government and community groups that help with systems coordination and advocacy for health care transition. The key planning partners are: CYSHNS, DOE, SPIN, Hawaii State Council on Developmental Disabilities, Hilopa‘a F2FHIC, BBH, DDD, Hawaii Maternal Child Health Leadership Education in Neurodevelopmental & Related Disabilities (MCH-LEND), Community Children’s Council Office, Division of Vocational Rehabilitation, and other organizations.

Utilizing partnerships to expand outreach efforts is a key concept promoted through NWD and DDD CoP. CYSHNS

staff is housed on the neighbor islands of Hawaii, Kauai, and Maui (which provides services on Lanai and Molokai islands), and on the most populated island of Oahu. The Kauai, West Hawaii, and Hilo Legislative Disability Forums provide another opportunity to share the transition messages. Through planning and participating in collaborative outreach events, CYSHNS further develops the network of agencies promoting transition.

Educational Materials

Comments shared by youth/families and self-advocates are essential to the development of transition educational material. The CYSHNS Transition Workgroup meets monthly to develop new ideas for outreach material based on consumer feedback. A frequent topic is how to develop high impact materials that can be understood across the literacy spectrum. Some at-risk groups are from the Federated States of Micronesia, Republic of the Marshall Islands, Mexico, or families with a parent/other family member who has a disability. CYSHNS develops transition materials that are shared and often used by partner organizations.

CYSHNS is also reviewing an Adolescent Resource Toolkit (ART) currently under development by the Title V Adolescent Health program. The ART is being designed for youth and is intended to provide health information for teens through various media forms. The ART currently emphasizes the importance of adolescent wellness visits, but will incorporate information on planning for transition to adulthood and adult care.

Review of Action Plan

A logic model was developed for NPM 12 to review the alignment between the strategies, activities, measures and desired outcomes. By working on these two strategy areas, Hawaii hopes to increase the percentage of adolescents who receive transition services to adult health care.

Strategy 1 focuses on integrating the *Got Transition's Six Core Elements of Health Care Transition 2.0* into the CYSHNS service protocols to ensure CYSHNS youth and their families prepare for transition to adult health care. This framework identifies the different planning components that need to be addressed. CYSHNS will establish a model program system of standardized procedures, protocols, materials, and data collection methods which can be used by other agencies working with youth and transition.

The transition policy was developed and is on the CSHNB website. Education of staff in the different aspects of transition planning is ongoing and discussed regularly during the Transition Workgroup meetings. The database system is being upgraded and a data collection template has been developed to track/monitor clients of transition age and the readiness assessment used with families. The transition planning template underwent substantial revision with input from staff and families to create a simpler, usable format with clearer guidance. Transfer of Care and Completion is being addressed as staff continue work with the NWD project to streamline the referral system through collaboration with other service agencies. All aspects of the program work are carefully vetted youth and families.

Strategy 2 focuses on public health education and awareness based on national and local best practices. Through expanded partnerships, CYSHNS is able to reach more providers, youth and families to support and participate in transition planning.

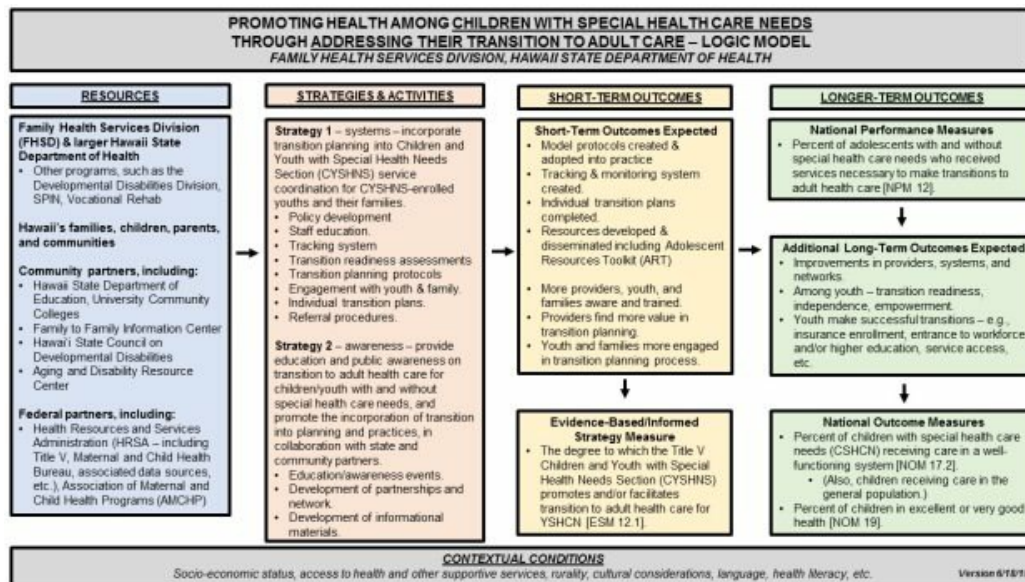
Staff bring health care transition issues to the table when meeting with youth, their families, or their networks. This message pertains to all youth, and many families instantly gravitate to the importance of skill-building and the shifting of responsibility to the youth, or they realize that they need to develop alternative arrangements. Outreach materials include flyers, Hilopa'a Personal Health Record and Workbook, and a fun fan (with transition tips) that help educate and increase awareness of transition. These are tools that can also help staff in their presentations or discussions

with others. CYSHNS will explore other methods to reinforce transition messaging.

CYSHNS will continue to provide expertise and support for transition to its various collaborative projects. Although staffing is limited, CYSHNS has learned to effectively utilize its key partners to advance transition planning through established community networks and to increase awareness of the importance of health care transition. CYSHNS will continue to explore new partnerships to improve health care outcomes for youth and their families.

In addition to meeting the ESM 12.1 and NPM 12, other long-term outcomes include:

- Improvement in transition services offered by providers, systems, and networks,
- Among youth – greater transition readiness, independence, empowerment.
- Evidence of more youth making successful transitions to adult care– e.g., insurance enrollment, entrance to workforce and/or higher education, and accessing adult care.



Based on input from youth and families, Hawaii modified its protocols by lowering the age when transition planning should begin from age 14 years to 12 years based on the individual situation. Developmentally appropriate *skill building* education should precede transition planning.

Challenges encountered

The major challenges to Strategy 1 concern the development of the new database system. Conversion from the old DOS system to an Access database is tedious, but tremendously important. Once completed, the new system will be vastly more efficient and user friendly. Staff will be able to generate reports, monitor and track transition practice, etc. Progress continues on the database upgrade with a hopeful completion date of December 2018.

For Strategy 2, the major challenge is maintaining adequate staff time and resources to work on partnership events. Since 2009, two CYSHNS positions were eliminated and one position remains vacant. Existing staff have increased caseloads and duties. Many other agencies also suffered staffing cuts during the 2009 recession; thus staff time and resources for community partnerships are limited. To encourage greater collaboration across sectors, the challenge is to illustrate the clear benefits to shared client populations.

Another challenge is to develop methods to measure progress and effectiveness of health education and awareness activities.

Additionally, technical assistance is needed to design more effective messaging and outreach methods to youth including use of social media and technology. The partnership with the Adolescent Health program will help address this concern, as the Adolescent Resource Toolkit is developed.

Overall impact

Over the past 6 years, incredible progress was made to build a system of service providers and agencies to help Hawaii youth transition to adulthood. CYSHNS successfully integrated transition planning into its services and helped to promote the message publicly in partnership with community programs and agencies. Since Maui held its first transition fair, events are held annually across all counties and have expanded to include a comprehensive array of service and educational providers. Hosted by the DOE, the Transition Fairs have created other outreach, educational events for the public as well as workforce training events for providers.

The CYSHNS Transition Workgroup meets monthly to review progress, revise/discuss materials, and decide next steps. Throughout the process, youth/family input is obtained at meetings, special events, or during various contacts. Feedback is collected and is used to revise the Readiness Assessment, skills building materials, and guidelines.

A special effort was made to assure feedback is solicited and received from youth and their families. Evaluations/comments from Transition Fair participants directly impact the planning for future events. Comments include what information they would like next, feedback on speakers and exhibits, scheduling suggestions, and location convenience (i.e., parking, air conditioning).

Children with Special Health Care Needs - Application Year

NPM 12-Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

For the CSHCN population domain, Hawaii selected NPM 10 transition to adult health care based on the results of the 5-year needs assessment. Plans to address this measure are discussed below.

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

The following are CYSHNS planned activities based on the ESM 12.1 Data Collection Form “The degree to which the Title V CYSHNS promotes and/or facilitates transition to adult health care for YSHCN”.

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.	<ul style="list-style-type: none"> • The policy was completed and disseminated. There are not further plans for this activity.
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.	<ul style="list-style-type: none"> • Continue to implement and study current practice to identify how CYSHNS may improve the approach so that transition is a familiar and friendly concept. • Continue the education of staff and 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.	<ul style="list-style-type: none"> • Establish the CYSHNS process for staff to input and track transitioning youth in the CYSHNS database. • Continue upgrading the CSHN Program client database to an Access system with the capacity to generate 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.	<ul style="list-style-type: none"> • Work with the database developer to incorporate the flow sheet into the Access database so staff can easily track and monitor transition progress.
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).	<ul style="list-style-type: none"> • Finalize pre-transition handout for children under age 12 years and accompanying talking points. • Finalize Transition Readiness Assessment form and accompanying talking points. • Develop guidelines for the pre-transition handout and Transition Readiness Assessment form.
6. Jointly develop goals and prioritized actions with youth and	<ul style="list-style-type: none"> • Work toward consensus on a standardized tool for developing and documenting goals and action in a

Item	FFY 2018 Plans
parent/caregiver, and document in a plan of care.	person-centered plan of care. <ul style="list-style-type: none"> • Obtain feedback from youths/families and review various planning tools.
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.	<ul style="list-style-type: none"> • Examine whether Transition Readiness Assessment form and the 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • Continue participation in the NWD network of agencies working to streamline the process of making and receiving referrals for long-term care services.
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.	<ul style="list-style-type: none"> • Continue work toward effectively helping families prepare for adult health care, using the tools and procedures that are being developed.

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 outreach/education events for youth and their families. The events include the DOE-hosted Transition Fairs, annual statewide SPIN Conference, Special Olympics, Malama da Mind, legislative forums, Marshallese Day, Healthy From Head to Toe, You Can't Have Inclusion Without Us, Parent Child Fair, and Keiki Steps.

Title V CSHCN Programs

Other CSHCN programs administered by the Title V CSHNB include:

Birth Defects: Provides population-based surveillance and education for birth defects in Hawaii and monitors major structural and genetic birth defects that adversely affect health and development.

Childhood Lead Poisoning Prevention: Hawaii received funding from Centers for Disease Control and Prevention (CDC) to reduce lead exposure and lead poisoning of children from birth through five years of age.

Children with Special Health Needs: Provides assistance with service coordination, social work, nutrition, and

other services for CSHCN age 0-21 years with chronic medical conditions. It serves children who have or may have long-term or chronic health conditions that require specialized medical care and their families.

Early Childhood: Focuses on systems-building to promote a comprehensive early childhood system with integrated system of policies, services, and programs that helps promote children with special health needs and all young children reach their optimal developmental health.

Early Intervention Section (EIS): Federal and state-mandated program that provides services to support the development of infant and toddlers from birth to three years of age.

Genetics Services: Provides information and education about topics in genetics and services to neighbor island families.

Newborn Hearing Screening: Provides newborn hearing screening for babies as required by Hawaii state law to identify hearing loss as soon as possible so that children can receive timely early intervention services.

Newborn Metabolic Screening: Provides newborn blood spot testing for babies as required by Hawaii state law. The tests help detect rare disorders that can cause serious health, developmental problems and even death if not treated early.

Hi'ilei Hawaii: Free resource for parents of children from birth to 5 years old. Hi'ilei provides developmental screening and information for families who are interested in supporting their young child to reach optimal development.

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator		
Numerator	8	11
Denominator	72	72
Data Source	Telehealth work group, Family Health Services Divi	The preliminary 5-year plan objectives were develo
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	11.0	11.0	11.0	12.0	12.0	12.0

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

Measure Status:	Inactive - Integrated into other measures rather than stand alone SPM
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State Provided Data		
	2016	2017
Annual Objective		29
Annual Indicator	23.9	23.9
Numerator	11	11
Denominator	46	46
Data Source	FHSD Staff Survey	FHSD Staff Survey
Data Source Year	2016	2016
Provisional or Final ?	Final	Provisional

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

Measure Status:	Inactive - Integrated into other measures rather than stand alone SPM
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State Provided Data		
	2016	2017
Annual Objective		18
Annual Indicator	13	13
Numerator	6	6
Denominator	46	46
Data Source	FHSD Staff survey	FHSD Staff survey
Data Source Year	2016	2016
Provisional or Final ?	Final	Provisional

State Action Plan Table

State Action Plan Table (Hawaii) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Improve access to services through telehealth

SPM

SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers.

Objectives

By July 2020, 100% of Title V programs use telehealth to provide services, education, and/or training.

Strategies

Telehealth infrastructure development: - Recruit staff from Title V programs and partners to form telehealth work group. - Develop and implement policies and procedures for telehealth in Title V programs. - Develop network of telehealth sites and personnel.

Workforce development: - Develop curriculum to train staff on the use of telehealth. - Implement training for staff. - Continuously evaluate training to make improvements to curriculum. - Implement long term follow-up of trainees to determine usefulness and use of training in their work.

Service Provision: - Identify services to be provided using telehealth. - Develop, implement, and evaluate pilot programs to implement telehealth for identified service. - Expand successful pilot programs

Education/Training: - Identify education and training to be provided using telehealth. - Develop, implement and evaluate pilot programs to implement telehealth for identified education and training. - Expand successful pilot programs.

SPM 1: The degree to which Title V programs utilize telehealth to improve access to services, education, and training for families and providers.

Introduction

Expanded use of telehealth technology was identified as a priority in the Title V 5-year needs assessment. By July 2020, 100% of Title V programs use telehealth to provide services, education, and/or training. With the reduction in personnel resources, increases in travel costs, availability of the internet, HIPAA compliant software, and affordable devices, telehealth can be one of the tools to increase access to services, education, and training for families and providers while reducing costs and travel time especially for neighbor island and rural communities.

The National Survey of Children with Special Health needs show that Hawaii children with special health care needs (CSHCN) have more difficulty accessing specialist care (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 Also, many specialized services are not available on each island, requiring costly air transportation to receive needed care. Use of telehealth in Hawaii for provision of genetics and behavioral health services have families and providers reporting high satisfaction with use of the technology and services provided.

There has been an increase in statewide efforts 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 DOH, 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 being 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.

There are 4 strategies for this measure: Infrastructure development, workforce development, service provision, and Education/Training. The strategies were developed by the FHSD staff, led by the CSHNB Genomics Section supervisor who serves as the FHSD lead for this priority.

Strategies to address this objective and NPM are discussed below.

Strategy: Telehealth infrastructure development

The Governor and the Director of Health continue to have telehealth as one of their top priorities for the state. The use of telehealth continued to increase including programs within the DOH, statewide hospitals, 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.

Senator Brian Schatz and his aides continue to meet with the DOH, University of Hawaii, and hospital representatives to discuss ways to increase the use of telehealth in Hawaii.

Third party payers and providers in the state are making progress on developing policies to implement Act 226 (2016) that removed the originating site restrictions so telehealth can be done to a person's home or work.

FHSD worked with the University of Hawaii to plan a statewide telehealth meeting which took place October 2017. State program staff, hospitals, healthcare providers attended the conference which covered current practices and policies and discussed needs for future support to expand telehealth in the state. FHSD staff presented about our telehealth activities and facilitated the break-out sessions to determine the needs of the community.

Strategy: Service Provision

Within FHSD, telehealth use is increasing for meetings, training, and education for staff and external partners. FHSD support continues its efforts to implement or increase telehealth clinical and service provision for genetics, newborn screening, early intervention, and home visiting activities. The Office of Primary Care and Rural Health continues to support Project ECHO Hawaii (echohawaii.org), which is an innovative model that utilizes videoconferencing to build primary care workforce capacity while improving patient access to specialty health care in rural communities. FHSD continues with the DOH Developmental Disabilities Division to support a pilot teledentistry program at three early childhood locations in Kona on Hawaii Island. The Early Intervention Section continues its telehealth work group to plan, implement, and evaluate using telehealth to provide early intervention services to families and training to staff and providers.

In May and June 2017, videoconferencing equipment was installed in the District Health Offices in Maui, Hilo, Kona, and Kauai. Training on the use of the equipment for the neighbor island FHSD staff is complete. The staff is using the equipment to facilitate telehealth visits for their neighbor island families. Genetics and neurology visits were completed using the technology. One child was not able to travel to Honolulu for the past two years to see a neurologist. He experienced too many seizures and other issues to make the airplane flight. The availability of telehealth allowed him to be seen by his neurologist and have his treatment management updated. This case started conversations to expand neurology and orthopedic telehealth clinics on Kauai by collaborating with the existing telehealth facilities at Wilcox Hospital and staff at Shriners Hospital.

Strategy: Workforce development

The telehealth training curriculum was implemented for FHSD staff. The training consists of nine on-line training modules and a one day in-person session. The HRSA funded Pacific Basin Telehealth Resource Center is worked with the Genomics Section to develop the in-person training to accompany the on-line telehealth training. The first training was launched at the end of September 2017 with the in-person training day on October 14th with 16 trainees from FHSD. We are working on revising the training based on feedback from the trainees. Dates are being chosen

for future training sessions.

Strategy: Education/Training

FHSD is also using videoconferencing on a daily basis for meetings and training. We have changed the vocabulary of the program staff and they routinely request to “Zoom” each other. We also have been able to schedule statewide training more easily since the trainings are now done using Zoom videoconferencing. The first major training sessions were done for childhood lead prevention.

State Performance Measure (SPM)

The FFY 2017 indicator for the SPM (The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers) is 11 out of 72. A copy of the completed data collection form can be found in the supporting documents. The Data Collection Form lists 24 strategy components organized by the three areas in telehealth activities:

- Infrastructure development
- Training/education development
- Service development

Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 72. Scoring is completed by FHSD staff. The data collection form is attached as a supporting document.

Factors Contributing to Success

The major factor contributing to success towards expanding telehealth in Title V programs continues to be support from the Governor, legislature, DOH administration, Division/Program leadership, program staff, and outside agencies such as the University of Hawaii and the HRSA funded Pacific Basin Telehealth Resource Center. The legislature approved funding during the 2017 legislative session for a State Telehealth Coordinator position with the DOH and development of a State Telehealth Plan. The DOH also consolidated the individual Zoom videoconferencing licenses into one HIPAA compliant corporate license to allow more efficient expansion for telehealth for our public health programs.

The prioritization of telehealth is pushing this Title V activity forward as a great example of what can be done in this area. The Title V activity also coincides with the telegenetics activities being developed and implemented as part of the HRSA funded Western States 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 more often without the cost and time for travel.

Challenges

The main challenge facing more rapid adoption of telehealth for the Title V programs is the limitation of staff time and competing priorities. As with other health departments, programs are experiencing staff retirements and departures with more difficulty filling positions with the many opportunities in the private sector. Since current staff continue to cover shortages, this can be a barrier to implement new opportunities in telehealth. However, the ability to reduce travel time and costs to attend meetings, trainings, and provide support and services to families makes it an attractive option for staff to make time to learn new skills.

Cross-Cutting/Systems Building - Application Year

SPM 1: The degree to which Title V programs utilize telehealth to improve access to services, education, and training for families and providers.

The objectives for SPM 1 were set based on anticipated completion of activities based on the work plan timetable. The Title V on-line telehealth training modules were implemented during FFY 2018 as part of the Title V training for staff and contracted providers. Evaluations are on-going to assess 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.

Title V Cross-Cutting/Systems Building Programs

Cross-cutting/Systems building programs administered by the Hawaii Title V program include:

Office of Primary Care and Rural Health: coordinates federal, state, and local efforts at improving the health of Hawaii's rural and medically underserved populations.

Primary Care Office: administers primary care contracts to improve access to primary care for medically underserved populations through the Community Health Centers, including Federally Qualified Health Centers (FQHC) and recruitment and retention of health care providers.

Rural Health: creates a focal point for rural health issues within each state, linking communities with state, federal and non-profit resources and helping to find long-term solutions. It keeps providers aware of new health care initiatives, collects and disseminate data and resources, and support workforce recruitment and retention. Contracts for rural hospitals provide essential access to inpatient, outpatient, and emergency medical services in rural communities

Oral Health: Hawaii is working to rebuild the state's dental public health infrastructure (statewide leadership, data surveillance and assessment, coalition building/partnerships, planning, evaluation, and communications) with funding from the Centers for Disease Control and Prevention.

Genetics Services: provides information and education about topics in genetics and services to neighbor island families.

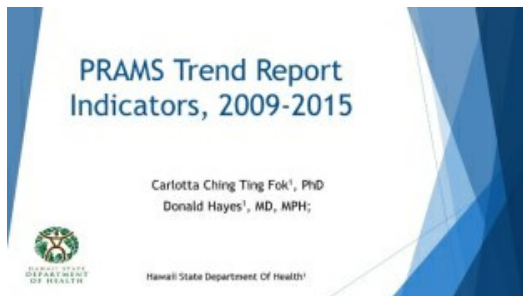
Critical Access Hospitals (CAH): there are 24 hospitals in Hawaii and 9 are identified as Critical Access Hospitals which assists small rural hospitals to improve access to health services in rural communities: Hale Hoola Hamakua, Kahuku Hospital, Kau Hospital, Kauai Veterans Memorial Hospital, Kohala Hospital, Kula Hospital, Lanai Community Hospital, Molokai General Hospital, Samuel Mahelona Memorial Hospital. The program helps to support CAHs with improvements in operational, financial, and clinical functions. Medicare Rural Hospitality Flexibility Grant Program (FLEX) provides federal funding for the program.

Hawaii, Maui, and Kauai District Health Offices: located on the less populated counties outside of Honolulu county which includes all of Oahu island. Within each DOH DHO there is an FHSD program managed by a Registered Nurse. The FHSD Nurse managers oversee personnel for WIC and CSHN including Early Intervention Services. Based on the organizational structure of the DHO and community needs, FHSD Nurse coordinators also manage a substantial range of other responsibilities including convening local death review teams, participating/convening numerous coalitions and advisory groups for FHSD and other DOH and DHS programs, and may also assist with monitoring for FHSD service contracts in their counties.

III.F. Public Input

Family Health Services Division (FHSD) involves communities, stakeholders, and program participants, including families, in policy and program decision-making at many levels. 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. Much of the Title V work is done in partnership. Depending on the community collaboratives that help determine strategies, assist with implementation, reassessment and revision of activities.

Because FHSD does not use Title V funds to fund local health departments or community based providers, there are no stakeholders with a vested interest in Title V as a funding source. Most of FHSD partners are aware of the importance of the Title V funding to support the FHSD programs and services provided to the community especially those who also receive HRSA/MCH Bureau funding. The challenge for FHSD is to develop effective avenues to engage stakeholders, including families and consumers, in the Title V work and the importance of MCH as a field in public health.



MCH assessment data, priorities, strategies, performance measure trends, and outcomes are regularly presented and reviewed by stakeholders and Title V implementing partners across the State.

FHSD engages and solicits input from community based organizations, safety-net providers and consumers in both the 5-year needs assessment and ongoing work to develop strategies

and implement the Title V 5-year plan.

Mechanisms through which input is solicited include: the Department of Health (DOH) website, surveys, community meetings, conferences, partner meetings, advisory groups, inter-agency committees, task forces, collaboratives, and focus groups.

Title V management, neighbor islands offices, and priority issue leaders continue to reach out and solicit input from partners around the state for each of the identified priorities utilizing a number of user-friendly products including a summary of the 5-year plan or fact sheets.



- Birth, Death and Other Records
- Online Marriage or Civil Union
- Current Advisories & Warnings
- Contact Us

HEALTH & SAFETY TOPICS

AGING AND DISABILITY PROGRAMS

WHAT'S NEW

- Maternal and Child Health Services Title V Block Grant
- Food Safety During Severe Weather

State of Hawaii, Department of Health
Family Health Services

Home About DOH Neighbor Island Offices News Employment

Home / Home Page for Family Health Services Division / Title V Maternal & Child Health Block Grant

TITLE V MATERNAL & CHILD HEALTH BLOCK GRANT

The Maternal and Child Health Services Block Grant (Title V of the Social Security Act) is the only federal program devoted to improving the health of all women, children and families. Title V provides funding for state maternal and child health (MCH) programs, which serve 35 million women and children in the U.S.

Since 1988, federal funds have supported state activities that improve the health of pregnant women, children, adolescents, and children and youth with special health needs (commonly called the "MCH population"). In Hawaii, the funds are used primarily to address maternal and child health infrastructure building services including:

- Surveillance and data about the health status of Hawaii's maternal and child health population;
- Assessment and monitoring of needs to assure health and wellness;
- State and local collaboration to assure access to preventive health services and information; and
- Linkages to health care and other maternal and child health services in the community.

The Hawaii Department of Health, Family Health Services Division (FHSD) is responsible for the administration of the Federal MCH Block Grant Funds.

The Title V 2016 Report and 2018 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/fhspd/home/title-v-maternal-child-health-block-grant/> For ease of access, the Executive Summary is available through a separate link.

Following the submission of the Title V application to the federal MCH Bureau in July 2018, 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 366 hits, no specific comments were received.

**Title V Update
 Priorities for Maternal and Child Health**

The Maternal and Child Health Services Block Grant, Title V of the Social Security Act, is the only federal program devoted to improving the health of all women, children and families. This program is managed by the Family Health Services Division (FHSD) in the Department of Health.

A Life Course Approach for FHSD Priorities

Early life events have a profound effect on an individual's health and well-being throughout their life.

National and State Priorities for 2015-2020: Measures and Activities

- Women's Health:** Promoting the best health of women to improve pregnancy and infant outcomes. Activities include: providing prenatal care, promoting breastfeeding, and ensuring safe delivery.
- Screening:** Ensuring that all children and youth are screened for developmental delays, hearing loss, and vision problems.
- Healthy Living:** Promoting healthy behaviors and environments for children and youth, including: ensuring safe drinking water, promoting physical activity, and ensuring a healthy diet.
- Child Abuse and Neglect:** Ensuring that all children and youth are protected from abuse and neglect. Activities include: ensuring that all children and youth are in safe environments, promoting positive parenting, and ensuring that all children and youth are in safe environments.

In 2017, FHSD developed several informational products to educate community stakeholders on the Title V priorities and to collect public input. The products were updated for 2018 and are also available on the website. Included are:

- Title V Update on Priorities for Maternal and Child Health, with information on update of measures and activities for Hawaii Title V priorities and strategies, and

information and data on the priorities.

- 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.



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.

FHSD staff utilize 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 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.

A new project will be launched August 2018 to develop standardized descriptions for all FHSD programs to update the FHSD website. Currently, each program develops informational materials and online resources independently. A communication consultant has been retained for this project and an initial template has been developed for FHSD program staff for review and comment. The Title V block grant will be included as part of project scope. Results will be shared in next year’s report.

Public and stakeholder input is generally favorable regarding the Title V priorities and supportive of the measures. Examples of public feedback that changed elements of the Title V 5-year plan strategies follow.

- NPM 1 Women’s Wellness Visits. The work for the priority is conducted in partnership with the Hawaii Maternal and Infant Health collaborative. The strategies for NPM 1 were revised slightly to focus on the two projects for the group: promoting One Key Question as a best practice and integrating Long
- 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: The 3 mechanisms for community input include the Hawaii Children's Trust Fund (HCTF) Advisory Committee (AC11 private and five public members, the HCTF Coalition's members of about approximately 30 active members representing key community partners working to prevent child maltreatment across the islands, and the Prevent Child Abuse Hawaii, Child Abuse Prevention Planning Council comprised of 15 active members representing the military and community-based private agencies. All of these groups serve a range of consumers and participate in their respective membership to be a voice for their communities. Comments from these groups refocused FHSD efforts on building a surveillance system to identify data sources and develop means for data sharing.
- 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. Pediatricians 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. Input from adolescents is being used currently to develop a teen-centered online resource for health information.
- 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 health 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 launched a year long process to develop a state oral health strategic plan. Input has been collected through the state oral health coalition, an online survey, community meetings held on all the islands, culminating in a statewide conference in May 2018. The plan will be completed by September 2018 and will be reviewed with community input and updated annually.

Feedback/comments that are more specific obtained at in-person meetings and by survey included:

- Reviewing the Title V NPM and SPM, there was strong sentiment that CAN prevention must be retained as a state priority, the need for improved data, and identifications of evidence based/best practices;
- 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.
- 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.

In preparation for next year's report, FHSD will develop a reporting form for staff leaders to document specific feedback collected over the next year for this narrative.

III.G. Technical Assistance

With the loss of the University of Hawaii Office of Public Health Studies Maternal Child Health certificate program, national technical assistance becomes critically important to develop foundational leadership and core public health skills and competencies. Thus, FHSD relies heavily on the national resources and technical assistance provided by the Maternal Child Health (MCH) Bureau and Association of Maternal and Child Health Programs (AMCHP) including learning labs, consultation with program officers and subject matter experts, Region IX conference calls, and national partnership conferences.

Hawaii will be participating in the July 2018 MCH Workforce Development Center Skills Building Institute with a focus to strengthen the Title V child maltreatment program (SPM 4) by a developing a child abuse and neglect surveillance system and conduct systems mapping to identify assets and needs to improve service provision and leverage resources. Hawaii also intends to participate in the October 2018 Title V Partnership meeting.

The Title V agency continues to partner with the MCH Leadership Education in Neurodevelopmental Disabilities (LEND) program to provide direct TA and training for the Title V Leadership team that includes program staff serving as lead for the national and state priority issues. In addition, LEND routinely recruits participants for their training cohorts from Title V staff including those on the neighbor islands.

In 2018, Hawaii Title V is embarking on new TA/professional development partnerships with the University of Hawaii School of Medicine public health faculty, Dr. Jeanelle Sugimoto-Matsuda (as described in the Needs Assessment update) and a new training consortium developed to support public sector employees, *One Shared Future* (as described in the Workforce Development narrative). A TA request to MCHB may be submitted in the future to help supplement/enhance these efforts.

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 - [Logic models.pdf](#)

Supporting Document #02 - [Family partnership survey.pdf](#)

Supporting Document #03 - [maps.pdf](#)

Supporting Document #04 - [GLOSSARY OF TERMS.pdf](#)

Supporting Document #05 - [Data Collection Forms.pdf](#)

NPM-01 - PROMOTING WOMEN'S/MATERNAL HEALTH THROUGH PREVENTIVE MEDICAL VISITS – LOGIC MODEL
FAMILY HEALTH SERVICES DIVISION, HAWAII STATE DEPARTMENT OF HEALTH

RESOURCES

Hawaii State Department of Health (HSDOH)

- Family Health Services Division (FHSD)
- Maternal Mortality Review
- HSDOH Strategic Plan

Early Childhood Action Strategies

Executive Office of Early Learning/Draft State Early Childhood Plan

Hawaii's families, children, parents, and communities

Local partners, including:

- **Hawaii Maternal and Infant Health Collaborative (HMIHC)** and associated workgroups
- Healthcare providers, hospitals, and pharmacy, community
- Queen's Clinically Integrated Physician Network
- Hawaii Department of Human Services (DHS), including State Medicaid Program
- University of Hawaii at Mānoa, John A. Burns School of Medicine
- Other local organizations – American Congress of Obstetricians and Gynecologists-Hawaii, Healthy Mothers Healthy Babies, March of Dimes

National partners, including:

- National Infant Mortality Collaborative Improvement and Innovation Network (CollIN)
- Health Resources and Services Administration (HRSA – including Title V, Maternal and Child Health Bureau, associated data sources, etc.), Association of Maternal and Child Health Programs (AMCHP)

STRATEGIES & ACTIVITIES

Strategy 1 – Promote pre/inter-conception health care visits.

- Promotion of evidence-based practices:
 - One Key Question® (OKQ)
 - Long-Acting Reversible Contraception (LARC)
- Provider trainings – OKQ; family planning, contraception options & costs, pregnancy prevention & spacing, community resources, client-centered techniques, challenging scenarios
- Development & dissemination of awareness materials – informational sheets for consumers, training packets for providers
- Messaging to women (teens) & the general public on importance of women's health: SafeSex808

Strategy 2 – Promote reproductive life planning.

- Increasing access to contraception & planning services.
- Data collection through provider surveys to guide activities with multi-cultural population

Strategy 3 – Systems building

- Facilitating information-sharing, networking, collaboration, coordination among public-private partners.
- Promoting guidance, provider protocols, assure cultural sensitivity
- Promoting policy, identifying & addressing barriers to access services, conducting evaluation & data collection

SHORT-TERM OUTCOMES

Short-Term Outcomes

Women (teens):

- Increased awareness of pregnancy intention, capacity to address reproductive health.
- Increased empowerment around reproductive life planning, accessing & speaking to providers.

Providers:

- Knowledge & capacity increased, barriers decreased.
- Overall self-efficacy increased to talk with, counsel patients & refer to additional services.

Organizations & Systems:

- Elimination of barriers, increased access to affordable services
- Build capacity/resources to sustain outreach/services.
- Analysis of data to target messaging

Evidence-Based/Informed Strategy Measures

- **% of births with less than 18 months spacing between birth & next conception [ESM 1.1]**

LONGER-TERM OUTCOMES

National Performance Measure

- % of women ages 18-44 who had a preventive medical visit in the past year [NPM 1].
- % of adolescents (12-17) with preventive medical visit in the past year [NPM 10]

Additional Long-Term Outcomes Expected

Infants:

- On-track health and development.

Women (teens):

- Increased birth intention
- Increased access to family planning services, reproductive health planning
- Good healthcare practices, prevention and management of chronic disease.

Providers, organizations, and systems:

- Services and systems are strengthened.
- More integration among disciplines and collaboratives.

National Outcome Measures

- Reduce maternal morbidity [NOM 2] and mortality [NOM 3].
- Reduce low birth weight [NOM 4.1], very low birth weight [NOM 4.2], and moderately low birth weight [NOM 4.3] deliveries.
- Reduce preterm [NOM 5.1], early preterm [NOM 5.2], late preterm [NOM 5.3], and early term [NOM 6] births.
- Reduce perinatal [NOM 8], infant [NOM 9.1], post neonatal [NOM 9.3], preterm-related [NOM 9.4], and sleep-related sudden unexpected infant (SUID) [NOM 9.5] deaths.

CONTEXTUAL CONDITIONS

Socio-economic status, access to health and other supportive services, rurality, cultural considerations, language, health literacy, etc.

NPM-04A, 04B - PROMOTING PERINATAL/INFANT HEALTH THROUGH THE PROMOTION OF BREASTFEEDING – LOGIC MODEL

FAMILY HEALTH SERVICES DIVISION, HAWAII STATE DEPARTMENT OF HEALTH

RESOURCES

Hawai'i State Department of Health (HSDOH)

- Family Health Services Division (FHSD), including programs such as: Women, Infants, and Children (WIC) program; Home Visiting Program
- Larger Hawai'i State Department of Health, including Chronic Disease Prevention and Health Promotion Division

Hawai'i's families, children, parents, and communities

Local partners, including:

- Hawai'i Maternal and Infant Health Collaborative (HMIHC)
- Breastfeeding Hawai'i
- Collaborative Leaders Network
- Healthy Mothers Healthy Babies
- Hawai'i Chapter of American Academy of Pediatrics
- Hawai'i Section of the American College of Obstetricians and Gynecologists
- March of Dimes

National partners and strategies:

- Health Resources and Services Administration (HRSA – including Title V, Maternal and Child Health Bureau, associated data sources, etc.), Association of Maternal and Child Health Programs (AMCHP)

STRATEGIES & ACTIVITIES

Strategy 1 – peer-to-peer programs – strengthen programs that provide mother-to-mother support and peer counseling.

- Training – e.g., engaging families and moms as peers.
- Service – utilization of peer-to-peer models in WIC programs.

Strategy 2 – WIC locations – use community-based WIC organizations to promote and support breastfeeding.

- Training – with providers (e.g., through home visiting program).
- Service – supports such as Text 4 Baby, breast pump loans, etc.
- Infrastructure – support of WIC locations to implement direct services, including breastfeeding and nutrition services, food assistance, and service referrals.

Strategy 3 – collaboration and networking

- Engaging in key partnerships (e.g., HMIHC).
- Ensuring consistent messaging for mothers, families, and the public.
- Advocacy and overall statewide coordination.

SHORT-TERM OUTCOMES

Short-Term Outcomes Expected

- Development of messages and relevant awareness materials.
- More providers trained, including for peer-to-peer programs.
- Increase of providers' knowledge.
- More providers promoting breastfeeding, providing information to families, and making referrals to supportive services as needed.
- Increased awareness and knowledge among mothers and families.
- Increased facilitators and decreased barriers for mothers to breastfeed.

Evidence-Based/Informed Strategy Measures

- Percent of WIC infants ever breastfed [ESM 4.1].

LONGER-TERM OUTCOMES

National Performance Measures

- Percent of infants who are ever breastfed [NPM 4a].
- Percent of infants breastfed exclusively through 6 months [NPM 4b].

Additional Long-Term Outcomes Expected

- Decreased stigma and increased acceptance around breastfeeding.
- Strengthening of provider services, organizational capacity, and support systems.

National Outcome Measures

- Infant mortality rate [NOM 9.1].
- Post-neonatal mortality rate [NOM 9.3].
- Sleep-related sudden unexpected infant deaths (SUID) [NOM 9.5].

CONTEXTUAL CONDITIONS

Socio-economic status, access to health and other supportive services, rurality, cultural considerations, language, health literacy, etc.

Version 6/1/18

NPM-05 - PROMOTING INFANT/PERINATAL HEALTH THROUGH SAFE SLEEP – LOGIC MODEL
FAMILY HEALTH SERVICES DIVISION, HAWAII STATE DEPARTMENT OF HEALTH

RESOURCES

Hawaii State Department of Health (HSDOH)

- Family Health Services Division (FHSD)
- Title V Safe Sleep Workgroup
- FHSD programs, including: Child Death Review; Community-Based Child Abuse Prevention grant; Early Childhood Comprehensive Systems grant; Hawaii Pregnancy Risk Assessment Monitoring System (PRAMS); Women, Infant, and Children (WIC) Program
- Other HSDOH branches (e.g., Injury Prevention)

Hawaii’s families, children, parents, and communities

Local partners, including:

- Hawaii State Department of Human Services (DHS; including ‘Ohana Nui Initiative)
- Local collaboratives (e.g., Hawaii Maternal and Infant Health Collaborative, Perinatal Nurse Manager Taskforce, Keiki Injury Prevention Coalition)
- Local hospitals
- Other organizations, including: Safe Sleep Hawaii, Child and Family Services, Hawaii Primary Care Association, Healthy Mothers Healthy Babies

National partners and strategies:

- Early Childhood Action Strategy, National Infant Mortality Collaborative Improvement and Innovation Network, Zero to Three
- Health Resources and Services Administration (HRSA – including Title V, Maternal and Child Health Bureau, associated data sources, etc.), Association of Maternal and Child Health Programs (AMCHP)

STRATEGIES & ACTIVITIES

Strategy 1 – Policy Development –

Implementation of safe sleep environment policies at birthing hospitals.

- Promoting role of hospitals.
- Strengthening and updating policies and implementation.

Strategy 2 – Assure Competent Workforce (training) – identify safe sleep competency training needs for birthing hospital professionals.

- Developing partnerships.
- Identifying and implementing training opportunities.

Strategy 3 – Inform, Educate, Empower. Public awareness and capacity-building – develop appropriate and consistent safe sleep messages to promote education and awareness among parents and the general public.

- Solicit input from family/community when Creating messages and informational materials (e.g., fact sheets, posters).
- Creating and disseminating messages through outlets such as DHS (TANF families, CWS, etc.), WIC, health plans, media campaigns, website, etc.
- Providing safe sleep materials (e.g., crib distribution).

SHORT-TERM OUTCOMES

Short-Term Outcomes Expected

- Parents and families increase awareness, capacity, and self-efficacy.
- Development of families and parents as advocates for safe sleep.
- Provider training opportunities identified; providers trained and prioritize safe sleep when meeting with families.
- Hospital protocols developed, strengthened, and institutionalized.

Evidence-Based/Informed Strategy Measures

- Increase % of birthing hospitals with current AAP safe sleep protocols [ESM 5.1].

LONGER-TERM OUTCOMES

National Performance Measure

- Increase % of infants placed to sleep on their backs [NPM 5].
- Additional Performance Measures**
(as measured through State PRAMS data)
- % of infants placed on a separate approved sleep surface.
 - % of infants placed to sleep without soft objects or loose bedding.

Additional Long-Term Outcomes Expected

- Healthy infant/child development (i.e., normal/within range).
- Early identification, referral, and services for any health challenges.
- Strengthening of organizations, partnerships, and overall network.

National Outcome Measures

- Reduction of infant mortality [NOM 9.1].
- Reduction of post-neonatal mortality [NOM 9.2].
- Reduction of sleep-related sudden unexpected infant deaths (SUID) [NOM 9.5].

CONTEXTUAL CONDITIONS

Socio-economic status, access to health and other supportive services, rurality, cultural considerations, language, health literacy, etc.

NPM-06 - PROMOTING CHILD HEALTH THROUGH DEVELOPMENTAL SCREENING – LOGIC MODEL

FAMILY HEALTH SERVICES DIVISION, HAWAII STATE DEPARTMENT OF HEALTH

RESOURCES

Family Health Services Division (FHSD) & State Department of Health (DOH)

- Title V Developmental Screening Work Group
- Other FHSD program, including Early Childhood Comprehensive Systems Impact grant
- Department of Health (DOH) Public Health Nursing

Community partners, including:

- American Academy of Pediatrics' Hawaii Chapter, and larger healthcare provider community
- Department of Human Services, including 'Ohana Nui initiative, Child Care Program Office, Med-QUEST
- Early Childhood Action Strategy
- Executive Office on Early Learning

Federal partners, including:

- Health Resources and Services Administration (HRSA) – Maternal Infant and Early Childhood Home Visiting (MIECHV), Association of Maternal and Child Health Programs (AMCHP)

Hawaii's families, children, parents, and communities

STRATEGIES & ACTIVITIES

- **Strategy 1** – Systems Development – promote guidelines and tool kit for providers
- **Strategy 2** – Family Engagement and Public Awareness – work with families to develop family-friendly material to promote developmental screening
- **Strategy 3** – Data Integration – develop internal data system for screening, referral, and services tracking
- **Strategy 4** – Policy and Public Health Coordination – develop infrastructure within FHSD to support developmental screening
- **Strategy 5** – Social Determinants of Health – identify and support specific vulnerable populations, with respect to child screening and development.

SHORT-TERM OUTCOMES

Short-Term Outcomes Expected

- Groundwork and infrastructure established and implemented for:
- Provider and family materials.
 - Data sharing.
 - Program evaluation (e.g., PPHC, disparities).
 - More providers and families aware and trained.
 - More resources disseminated.
 - Increased positive attitudes and skills, and decreased barriers, among providers and families.

Evidence-Based/Informed Strategy Measure

- Development and implementation of data sharing system for FHSD programs conducting developmental screening, referrals, and services [ESM 6.1 inactive].
- Implement Policy and Public Health Coordination (PPHC) rating scale to monitor infrastructure development within FHSD [ESM 6.2 new]

LONGER-TERM OUTCOMES

National Performance Measures

- Increase children receiving a developmental screening using a parent-completed screening tool.

Additional Performance Measures

- Increase children screened through other health providers.

Additional Long-Term Outcomes Expected

- Providers, programs, and systems are strengthened through infrastructure- and systems-building.
- More children are identified, referred, and receive appropriate services in a timely manner.
- Stigma (e.g., related to developmental delay) is decreased among providers and families.

National Outcome Measures

- More children meet criteria for school readiness [NOM 13].
- More children in excellent or very good health [NOM 19].

CONTEXTUAL CONDITIONS

Socio-economic status, access to health and other supportive services, stigma and cultural considerations, language, health literacy, gender.

NPM-10 - ADOLESCENT HEALTH – LOGIC MODEL
FAMILY HEALTH SERVICES DIVISION
HAWAII STATE DEPARTMENT OF HEALTH

RESOURCES

- Family Health Services Division & larger Hawai'i State Department of Health
- ART & Science Steering Committee
- Chronic Disease prevention
- Hawaii's families, children, parents, and communities
- Community partners – Hilopa'a Family to Family Information Center, American Academy of Pediatrics (AAP)-HI Chapter, Hawaii Maternal & Infant Health Collaborative, YRBS Data Committee
- Policies – AAP (Bright Futures guidelines); Affordable Care Act (prevention coverage); Hawai'i State Legislature Act 185 (7th grade well visits) & Act 181 (consent to mental health treatment)
- Federal partners – Health Resources and Services Administration (Title V, Maternal and Child Health Bureau, associated data sources), Association of Maternal and Child Health Programs (AMCHP)



STRATEGIES & ACTIVITIES

- **Strategy 1** – Collaboration – develop partnerships with key community stakeholders to develop/implement strategies to improve utilization of adolescent well care visits.
- **Strategy 2** – Youth & Family engagement and public awareness – develop common messaging to describe the value of adolescent well care visits among youth and parents.
- **Strategy 3** – Product development
 For Providers: Adolescent Resource Toolkit (ART)
 For Youth: Hawaii Adolescent Resource Toolkit (HART) & online resources
- **Strategy 4** – Workforce Development (training) – increase resources, training, and practice improvement supports for adolescent health providers to provide teen-centered, well-care visits aligned to *Bright Futures*.



SHORT-TERM OUTCOMES

- For Providers:
- Improved understanding of the importance & strategies to increase adolescent visits
 - Development and dissemination of Adolescent Resource Toolkit (ART) to primary care providers [ESM 10.1].
 - Primary care providers increase knowledge and skill in implementing adolescent well-care visit.
- For Youth & Families:
- Development and dissemination of Adolescent Resource Toolkit (ART) to youth.
 - Families and youth increase awareness and empowerment
 - Percent of adolescents (12-17) with preventive medical visit in the past year [NPM 10].



LONGER-TERM OUTCOMES

- Increased access to preventive services, such as:
- Increase of children with mental/behavioral condition who receive treatment or counseling [NOM 18].
 - Decrease of children who are overweight or obese [NOM 20].
 - Increase in children who are vaccinated for influenza [NOM 22.2], HPV [NOM 22.3], Tdap [NOM 22.4], and meningitis [NOM 22.5].
- ↓
- Reduction of adolescent mortality [NOM 16.1], including motor vehicle mortality [NOM 16.2] and suicide [NOM 16.3].
 - Increase of children in good health [NOM 19].
 - Hawaii's adolescents have healthy development, and are overall healthy and safe [priority need].

CONTEXTUAL CONDITIONS

Socio-economic status, rurality, cultural considerations, language and health literacy, etc.

**NPM-12 - PROMOTING HEALTH AMONG CHILDREN WITH SPECIAL HEALTH CARE NEEDS
THROUGH ADDRESSING THEIR TRANSITION TO ADULT CARE – LOGIC MODEL**
FAMILY HEALTH SERVICES DIVISION, HAWAII STATE DEPARTMENT OF HEALTH

RESOURCES

Family Health Services Division (FHSD) & larger Hawaii State Department of Health

- Other programs, such as the Developmental Disabilities Division, SPIN, Vocational Rehab

Hawaii’s families, children, parents, and communities

Community partners, including:

- Hawaii State Department of Education, University Community Colleges
- Family to Family Information Center
- Hawai’i State Council on Developmental Disabilities
- Aging and Disability Resource Center

Federal partners, including:

- Health Resources and Services Administration (HRSA – including Title V, Maternal and Child Health Bureau, associated data sources, etc.), Association of Maternal and Child Health Programs (AMCHP)

STRATEGIES & ACTIVITIES

Strategy 1 – systems – incorporate transition planning into Children and Youth with Special Health Needs Section (CYSHNS) service coordination for CYSHNS-enrolled youths and their families.

- Policy development
- Staff education.
- Tracking system
- Transition readiness assessments
- Transition planning protocols
- Engagement with youth & family.
- Individual transition plans.
- Referral procedures.

Strategy 2 – awareness – 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.

- Education/awareness events.
- Development of partnerships and network.
- Development of informational materials.

SHORT-TERM OUTCOMES

Short-Term Outcomes Expected

- Model protocols created & adopted into practice
- Tracking & monitoring system created.
- Individual transition plans completed.
- Resources developed & disseminated including Adolescent Resources Toolkit (ART)
- More providers, youth, and families aware and trained.
- Providers find more value in transition planning.
- Youth and families more engaged in transition planning process.

Evidence-Based/Informed Strategy Measure

- 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].

LONGER-TERM OUTCOMES

National Performance Measures

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

Additional Long-Term Outcomes Expected

- Improvements in providers, systems, and networks.
- Among youth – transition readiness, independence, empowerment.
- Youth make successful transitions – e.g., insurance enrollment, entrance to workforce and/or higher education, service access, etc.

National Outcome Measures

- Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system [NOM 17.2].
 - (Also, children receiving care in the general population.)
- Percent of children in excellent or very good health [NOM 19].

CONTEXTUAL CONDITIONS

Socio-economic status, access to health and other supportive services, rurality, cultural considerations, language, health literacy, etc.

NPM-13.2 - PROMOTING ORAL HEALTH AMONG HAWAII'S CHILDREN – LOGIC MODEL
FAMILY HEALTH SERVICES DIVISION, HAWAII STATE DEPARTMENT OF HEALTH

RESOURCES

- Hawaii State Department of Health (HSDOH)**
- Family Health Services Division (FHSD)
 - FHSD programs, including: State Oral Health Program; CDC-funded oral health state infrastructure-building grant; Women, Infant, and Children (WIC) services
 - Other HSDOH branches (e.g., Public Health Nursing)
- Hawaii's families, children, parents, and communities**
- Local partners, including:**
- Hawaii State Department of Human Services (DHS; including 'Ohana Nui Initiative)
 - Hawaii Coalition for Oral Health
 - Hawaii Public Health Institute
 - Youth-serving/focused organizations (e.g., Hawaii Children's Action Network, Head Start programs)
 - Primary care community (e.g., Hawaii Primary Care Association, West Hawaii Community Health Center)
 - Oral health community (e.g., Hawaii Dental Association, Hawaii Dental Hygiene Association, Hawaii Dental Service & Foundation)
- National partners and strategies:**
- Association of State and Territorial Dental Directors
 - Pacific Center for Special Care at the Arthur A. Dugoni School of Dentistry, University of the Pacific
 - Health Resources and Services Administration (HRSA – including Title V, Maternal and Child Health Bureau, associated data sources, etc.), Association of Maternal and Child Health Programs (AMCHP)

STRATEGIES & ACTIVITIES

- Strategy 1** – Develop program leadership and staff capacity.
- Ensure full staffing of relevant programs.
 - Build and maintain program operations and systems.
- Strategy 2** – Develop or enhance oral health surveillance.
- Implementation of state oral health surveillance plan.
 - Primary data collection (e.g., basic screening survey).
- Strategy 3** – Assess facilitators/barriers to advancing oral health.
- Assessment activities (e.g., environmental scan) to inform strategic planning.
- Strategy 4** – Develop and coordinate partnerships with a focus on prevention interventions.
- Exploration of new partnerships, piloting of innovative activities, and leveraging of resources (e.g., teledentistry project, virtual dental home, etc.).
- Strategy 5** – Develop plans for state oral health programs and activities.
- Ongoing strategic planning process with community partners and stakeholders.

SHORT-TERM OUTCOMES

- Short-Term Outcomes Expected**
- Increased capacity and teamwork among FHSD/Title V team.
 - Planning and piloting of innovative and data-informed prevention and intervention activities (e.g., teledentistry).
 - Strengthened connection and communication with community partners.
- Evidence-Based/Informed Strategy Measures**
- Leadership for the State Oral Health Program is established under the direction of a dental professional and staff with public health skills [ESM 13.1].
 - Completion of the teledentistry pilot project at three early childhood settings to reach underserved children [ESM 13.2].

LONGER-TERM OUTCOMES

- National Performance Measure**
- Percent of children, ages 1 through 17 who had a preventive dental visit in the past year [NPM 13.2].
- ↓
- Additional Long-Term Outcomes Expected**
- Oral health plans and systems in place – e.g., surveillance system, data collection systems, mechanisms for translating data into strategic recommendations and action, etc.
 - Increased connection to, and awareness among, children and families with respect to oral health.
- ↓
- National Outcome Measures**
- Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months [NOM 14].
 - Percent of children in excellent or very good health [NOM 19].

CONTEXTUAL CONDITIONS

Socio-economic status, access to health and other supportive services, rurality, cultural considerations, language, health literacy, etc.

FAMILY ENGAGEMENT SURVEY

FHSD Program Manager,

Thank you for agreeing to take part in this survey documenting opportunities for Family Engagement across all FHSD programs. The Division intends to use the survey results to:

- Help increase awareness and promote family engagement in all our programs;**
- Learn from our current practices by documenting and sharing the information;**
- Help develop methods to increase engagement of families in our work;**
- Identify ways the Division can support family engagement.**

The survey should take about 10 minutes to complete. The information will be compiled and summarized in a short report.

Family/consumer engagement helps to assure our programs are effectively addressing the needs of those we serve and is an important best practice for all state maternal and child health programs and agencies. Building the capacity of women, children and youth, including those with special health care needs, and families to partner in decision making is a critical strategy to achieve improved health outcomes. *The Title V Services Block Grant program defines family/consumer engagement as a 'partnership': "patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system - direct care, organizational design and governance, and policy making - to improve health and health care. This partnership is accomplished through the intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course."*

FHSD programs should work to assure families are key partners in health care decision-making at all levels in the system of services, especially those families who are vulnerable and medically underserved.

Below find a few questions regarding your program's family engagement activities. Please check all those that apply and please write-in other examples of family engagement not included in the checklist.

1. What are some of the methods you use to engage families? (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Advisory Committees/Task Forces | <input type="checkbox"/> Participation in training, both in orientation and ongoing professional development for staff, family leaders, volunteers, contractors in the area of cultural and linguistic competence |
| <input type="checkbox"/> Program Outreach | |
| <input type="checkbox"/> Family Surveys | <input type="checkbox"/> Family participation in training events together with community stakeholders and agency representatives |
| <input type="checkbox"/> Focus Groups | <input type="checkbox"/> Participation in program training activities with staff |
| <input type="checkbox"/> Family Events | <input type="checkbox"/> Participation in program activities with staff for peer support |
| | <input type="checkbox"/> Participation in program activities with staff supporting family champions |

Other (please specify)

2. Do you collect input or engage families, caregivers, youth for: (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Needs/Assets Assessments | <input type="checkbox"/> Review/development of program policies and procedures |
| <input type="checkbox"/> Program development, planning, and goal setting (including grant writing) | <input type="checkbox"/> Quality improvement initiatives |
| <input type="checkbox"/> Quality improvement activities | <input type="checkbox"/> Program evaluation and monitoring (eg. families/family organizations routinely receive information about evaluation results) |
| <input type="checkbox"/> Development of publications, education/outreach materials | <input type="checkbox"/> Supporting families to provide education and information about Maternal and Child Health (MCH) to policymakers and legislators |
| <input type="checkbox"/> Program activities/service delivery | <input type="checkbox"/> Supporting families to advocate for MCH issues, funding, and legislation to policymakers and legislators |

Other (please specify)

3. What are some other methods your program uses to engage families/assure family engagement: (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Family member as paid program staff | <input type="checkbox"/> Use family input when planning, creating and presenting of training materials |
| <input type="checkbox"/> Provide support funding for family run organizations | <input type="checkbox"/> Share program information routinely with family leadership, family-run organizations, families in need of services |
| <input type="checkbox"/> Provide stipends and/or in-kind supports for family participation | <input type="checkbox"/> Ensure programs reflect diversity of the families being served |
| <input type="checkbox"/> Contract with Family-led organizations for project funding | <input type="checkbox"/> Programs conduct outreach to all families in the community being served |
| <input type="checkbox"/> Maintain family engagement policy | <input type="checkbox"/> Designate an AMCHP family delegate for Hawaii |
| <input type="checkbox"/> Provide ongoing leadership development and communication skills training for families to assure families feel comfortable and able to participate | <input type="checkbox"/> Support family participation in local, state and national conferences |

Other (please specify)

4. What assistance do you need that can help increase your family engagement activities? (check all that apply)

- Assistance finding families/consumers
- Methods to compensate families/consumers for their time
- Staff training to increase knowledge about family engagement
- Sharing information/expertise among FHSD programs on how to engage families

Other (please specify)

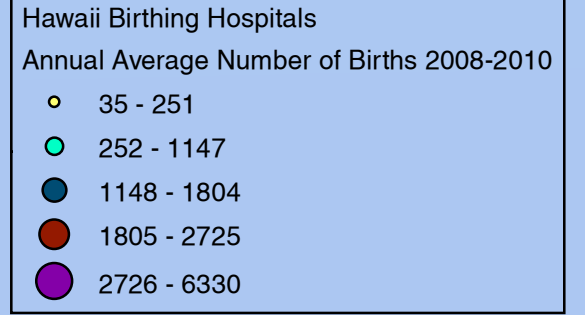
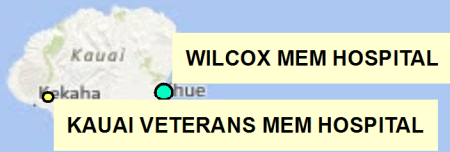
5. Please reflect how you feel about this statement: "This survey helped increase my understanding of family engagement opportunities and its importance for program improvement."

- | | |
|--|---|
| <input type="radio"/> Strongly agree | <input type="radio"/> Disagree |
| <input type="radio"/> Agree | <input type="radio"/> Strongly disagree |
| <input type="radio"/> Neither agree nor disagree | |

Comments?

Location of Birthing Hospitals in Hawaii

Kauai County



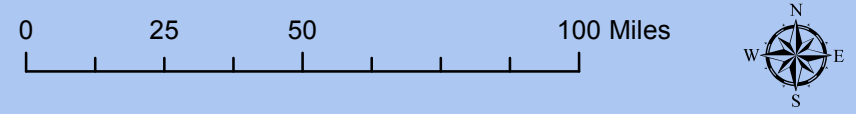
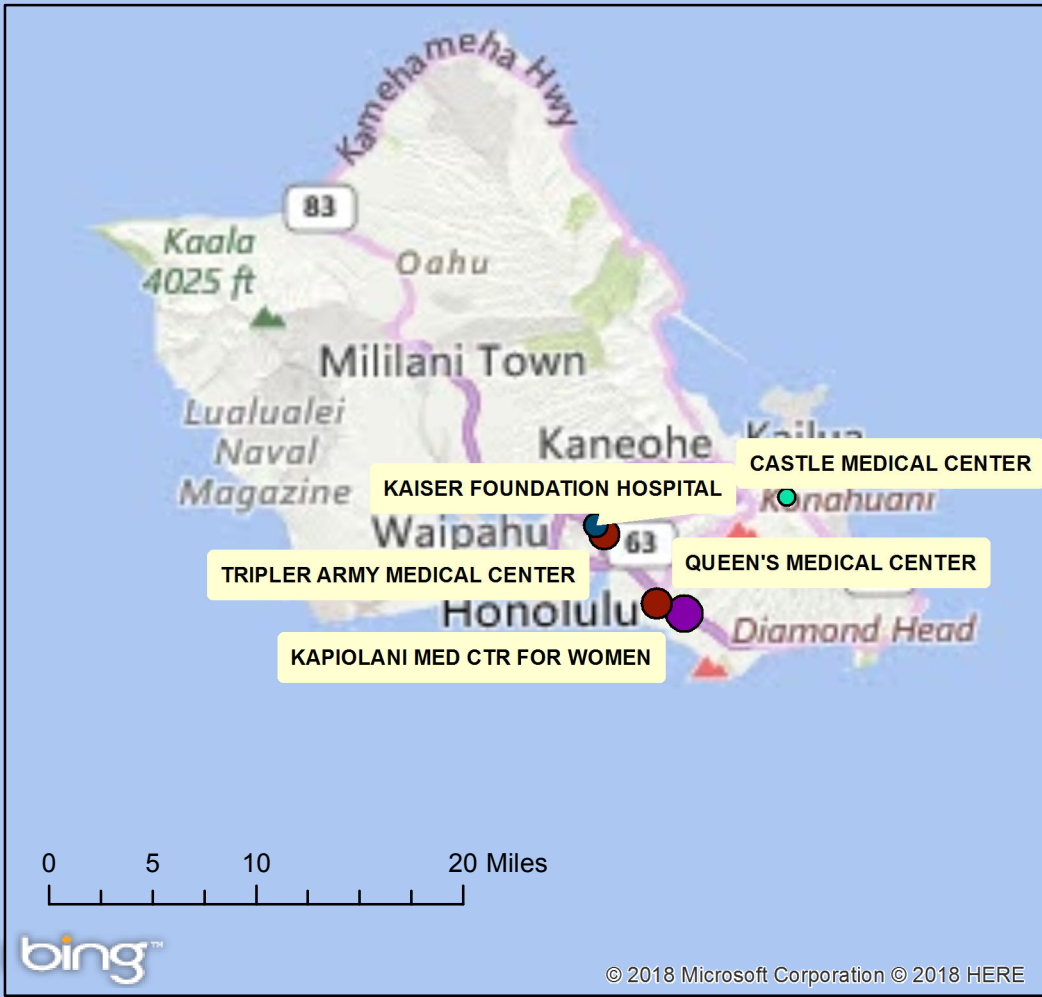
Honolulu County



Maui County

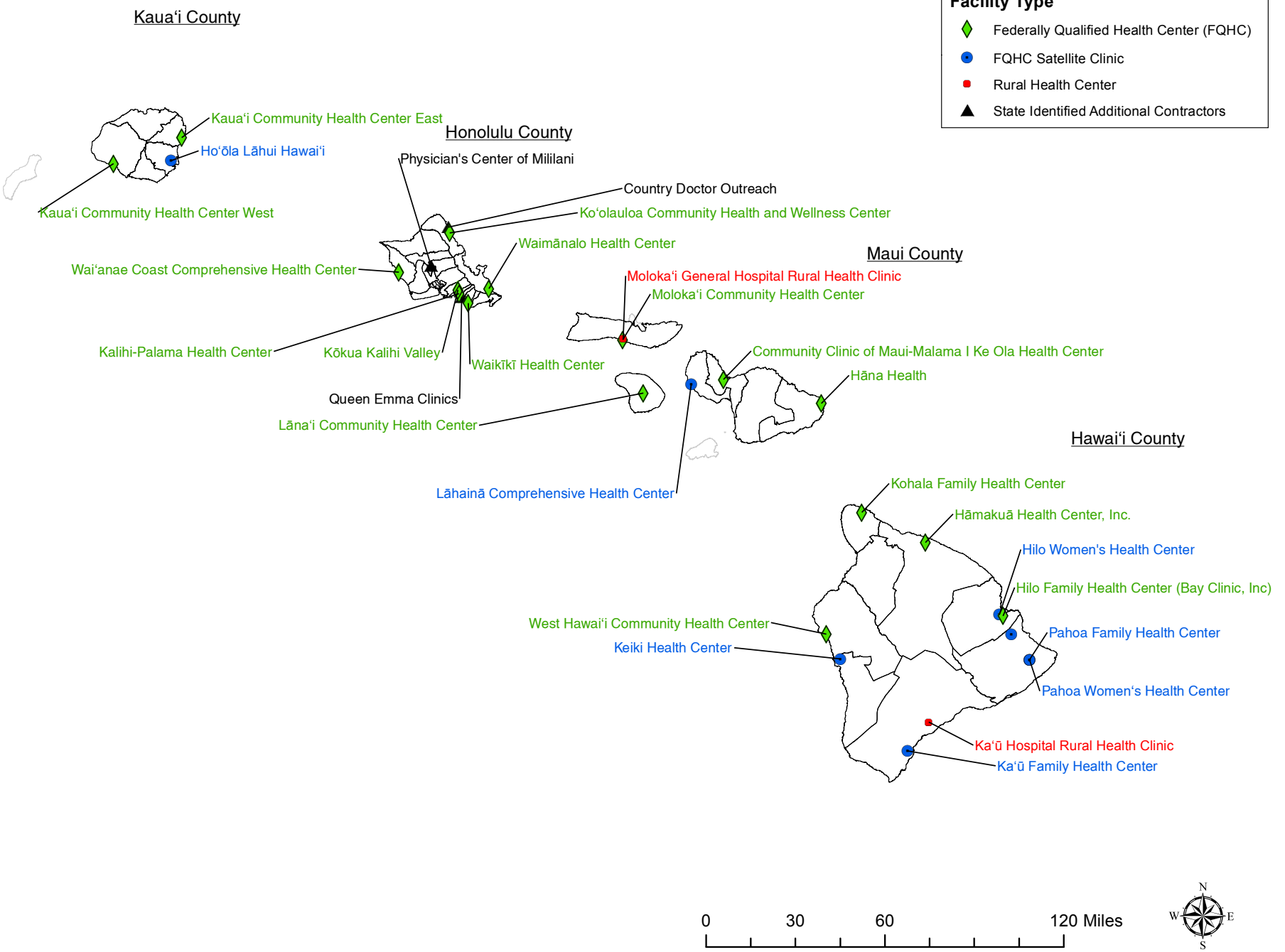


Hawaii County



Facility Type

- ◆ Federally Qualified Health Center (FQHC)
- FQHC Satellite Clinic
- Rural Health Center
- ▲ State Identified Additional Contractors



Map 2-3: Location of Community Health Centers and Clinics

GLOSSARY

AABR- Automated Auditory Brainstem Response
AAP- American Academy of Pediatrics
AAP-H- American Academy of Pediatrics- Hawaii Chapter
AB- Advisory Board
ABD- Aged, Blind, and Disabled population
ABLE - Achieve a Better Life Experience Act
AC- Advisory Committee
ACA- Affordable Care Act
ACIP- Advisory Committee on Immunization Practices
ADAD- Alcohol & Drug Abuse Division
AEP- Abstinence Education Program
AMCHP- Association of Maternal and Child Health Programs
ARRA- American Recovery and Reinvestment Act
ASD- Autism Spectrum Disorder
ASTHO - Non-profit public health organization representing the leaders of State and Territorial health agencies.
ASIST- Applied Suicide Intervention Skills Training
ASQ- Ages & Stages Questionnaire
ASQ-SE- Ages & Stages Questionnaire- Social Emotional
ASTDD- Association of State & Territorial Dental Directors
BGCH- Boys and Girls Club of Hawaii
BESSD- Benefit, Employment, and Support Services Division
BFHP- Baby Friendly Hawaii Project
BFC – Breastfeeding Coordinator
BFPC- Breastfeeding Peer Counselor Program
BIPHDP- Big Island Perinatal Health Disparities Program
BMI- Body Mass Index
BRFSS- Behavior Risk Factor Surveillance System
CAN- Child Abuse & Neglect
CAPP- Child Abuse Prevention Planning Council
CBCAP- Community Based Child Abuse Prevention Program
CCC - Community Children’s Council
CCHD- The Critical Congenital Heart Disease
CDHP- Children’s Dental Health Project
CDR- Child Death Review
CHC- Community Health Centers
CHIL- Hawaii’s Children’s Healthy Living Program for Remote Underserved Minority Population in the Pacific Region Project
CHIPRA- Children’s Health Insurance Program Reauthorization Act of 2009
CMS- Centers for Medicare & Medicaid Services
CMV- Congenital Cytomegalovirus
CoIIN- Hawaii’s Infant Mortality Collaborative Improvement and Innovation Network
CQI- Continuous Quality Improvement
CRDG - Curriculum Research & Development Group
CRT- Children’s Research Triangle
CS- Oahu’s Complete Streets
CSC- Child Safety Collaborative
CSHCN- Children with Special Health Care Needs
CSHNB- Children with Special Health Needs Branch
CSHNP - Children with Special Health Needs Program
CSN- Children’s Safety Network
CSP- Hawaii Child Safety Program
CSTE- Council of State and Territorial Epidemiologists
CWS- Child Welfare Services
CVV- Cash Value Vouchers
CY- Calendar Year
CYSHCN- Children & Youth with Special Health Care Needs
DBEDT- Department of Business, Economic Development and Tourism

DCAB - Disability and Communication Access Board
 DD- Developmental Disabilities
 DDD- Developmental Disabilities Division
 DHD- Dental Health Division
 D/HH- Deaf/Hard of Hearing
 DHO- District Health Offices
 DHS- Department of Human Services
 DOE- Department of Education
 DOH- Department of Health
 DV- Domestic Violence
 DVR- Division of Vocational Rehabilitation
 ECCS- Early Childhood Comprehensive Systems
 EHDI- Early Hearing Detection and Intervention
 EHR- Electronic Health Record
 EHS- Early Head Start
 EI- Early Intervention
 EIS- Early Intervention Services
 EMSC- Emergency Medical Services for Children
 EOB-Explanation of Benefits
 EOEL- Executive Office on Early Learning
 EPC- Emergency Pediatric Care
 EPSDT- Early and Periodic Screening, Diagnostic and Treatment Services
 ESTN- Enhancing the Statewide Trauma Network program
 F2F- Family to Family Health Information Center
 FASD- Fetal Alcohol Spectrum Disorder
 FCIL- The Native Hawaiian Family Child Interaction Learning Programs
 FELSI- Financial, Ethical, Legal and Social Issues
 FHSD- Family Health Services Division
 FIP- Family Individual Plan
 FPL- Federal Poverty Level
 FPP- Family Planning Program
 FQHC- Federally Qualified Health Centers
 FTE- Full-time Equivalency
 FTW- First-to-Work; Program serving parents receiving TANF.
 FV- Fluoride Varnish
 GBYS- Guide By Your Side; a parent mentor program.
 GLFRTC- Great Lakes FASD Regional Training Center
 GPRA- Government Performance and Results Act- Public Law 103-62
 GRADS- Graduating, Reality and Dual Role Skills
 H&V- Hands & Voices Hawaii Chapter
 HAEYC- Hawaii Association for the Education of Young Children
 HBA- Behavioral Health Administration
 HBDP- Hawaii Birth Defects Program
 HBIG- Hepatitis B immune globulin
 HCCI- Hawaii's Caring Communities Initiative
 HCFA- Health Care for All
 HCG- Hawaii Community Genetics
 HCTF- Hawaii Children's Trust Fund
 HDHO- Hawaii District Health Office
 HDOT- Hawaii Department of Transportation
 HDS- Hawaii Dental Service
 HEICC- Hawaii Early Intervention Coordinating Council
 HFA- Healthy Families America models
 HHIC- Hawaii Health Information Corporation
 HHVN- Hawaii Home Visiting Network
 HIOHTF- State of Hawaii Island Oral Health Task Force
 HIC- Hawaii Immunization Coalition
 HI-CHI- Hawaii Island Collaborative Health Initiative
 HICORE- The Hawaii Initiative for Childhood Obesity Research and Education
 Hilopa'a- "to braid firmly"; Integrated Systems for Children & Youth with Special Healthcare Needs in Hawaii

HIPP- Health Insurance Premium Payment Program
 HIPPY- Home Instruction for Parents of Preschool Youngsters
 HIR- Hawaii Immunization Registry
 HITOP- Hawaii County's Teen Outreach Program
 HMAA- Hawaii Management Alliance Association
 HMHB- Healthy Mothers Healthy Babies Coalition of Hawaii
 HMHB- Healthy Mothers, Healthy Babies
 HMO- Health Maintenance Organization
 HMSA- Hawaii Medical Service Association; also known as Blue Cross and Blue Shield plan
 Ho'opa'a- "fortify"- Ho'opa'a Hawai'i State Autism Implementation Grant
 HPC- Hawaii Perinatal Consortium
 HPCA- Hawaii Primary Care Association
 HPPUD- Hawaii Partnerships to Prevent Underage Drinking
 HRA- Health Resources Administration
 HRS- Hawaii Revised Statutes; typically seen as HRS SS 321-1.3
 HRSA- Health Resources Services Administration
 HS- Head Start
 HSCAV- Hawaii State Coalition Against Domestic Violence
 HSCI- Health System Capacity Indicator
 HSHS- Hawaii School Health Survey Committee
 HUD- Housing and Urban Development
 Hui Kupa'a- Hawaii's Collective Impact
 HV- Home Visiting
 HHVN- Hawaii Home Visiting Network
 HYH- Healthy Youth Hawaii
 HYSN- Hawaii Youth Services Network
 ICHIA- the Legal Immigrant Children's Health Improvement Act
 I/DD population – Intellectually & Developmental Disabled
 IDEA- Individuals with Disabilities Education Act
 IMR- Institute for Medical Research
 IPCS- Injury Prevention and Control Section
 IPCP- Injury Prevention and Control Prevention
 JABSOM- Jacob A. Burns School of Medicine
 KIPC- Keiki Injury Prevention Coalition
 KMCWC- Kapiolani Medical Center for Women and Children
 LAC- Local Area Consortia
 LBW- Low Birth Weight
 LEND- MCH Leadership Education Excellence in Caring for Children with Neurodevelopment and Related Disabilities
 MAC - Moving Across the Community (Transition Fair)
 MAGI- Modified Adjusted Gross Income
 MCAR- Mobilizing Communities At- Risk
 MCH- Maternal and Child Health
 M-CHAT- Modified Checklist for Autism in Toddlers
 MCHB- Maternal and Child Health Branch
 MCHLEND- Leadership Education in Neurodevelopment and Related Disabilities
 MIECHV- Maternal, Infant, and Early Childhood Home Visiting grant
 MOA- Memorandum of Agreement
 MQD- Med-QUEST Division; provides reimbursement to DOH for early intervention services for QUEST-eligible infants and toddlers who are developmentally delayed or biologically at risk.
 MV- Motor Vehicles
 NHSP - Newborn Hearing Screening Program
 NBMSPP- The Hawaii Newborn Metabolic Screening Program
 NCQA- National Committee on Quality Assurance
 NCSL - National Conference of State Legislatures
 NGA- National Governor's Association
 NHOPI- Native Hawaiian and Other Pacific Islander
 NI- Neighbor Island
 NPAC- the State Nutrition and Physical Activity Coalition
 NPM- National Performance Measures
 NRT- Neonatal Resuscitation Teams program

OAE- Otoacoustic Emissions
 OHA- Office of Hawaiian Affairs
 OHSM- DOH Office of Health Status and Monitoring
 PAN- Provider Accuracy Network
 PAN Plan- The Hawaii Physical Activity and Nutrition Plan 2013-2020
 PAT- Parents as Teachers
 PATCH- Hawaii's Child Care Resource and Referral agency.
 PCAH- Prevent Child Abuse Hawaii
 PCO- Primary Care Office
 PCMH- Patient-Centered Medical Home
 PCP- Primary Care Physician
 PDSA- Plan, Do, Study, Act cycle
 PedNSS- Pediatric Nutrition Surveillance System
 PHN- Public Health Nurse
 PNC- Prenatal Care
 PONO- Pursuit of New Opportunities
 PPO- Preferred Provider Organization
 PRAMS- Pregnancy Risk Assessment Monitoring Surveillance
 PREP- Personal Responsibility Education Program
 PREVENT Institute- Prevent Violence through Education, Network and Technical Assistant; based at the University of North Carolina School of Public Health.
 PSHTF- Prevent Suicide Hawaii Taskforce
 PSS- Perinatal Support Services
 PSW- Perinatal Smoking Workgroup
 QExA- QUEST Expanded Access program
 QI - QUEST Integration
 QUEST- Quality Care, ensuring Universal Access, encouraging Efficient utilization, Stabilizing costs, and Transforming the way health care is provided.
 QUEST-ACE- Adult Coverage Expansion
 QI- Quality Improvement
 RBRG- "Rainbow Book", Resource Guide
 RIF- Reduction in Force
 RRFB- Rectangular Rapid Flashing Beacon
 SCHIP- State Children's Health Insurance Program
 SCID- Severe Combined Immunodeficiency Disease
 SDBS- Standardized Developmental and Behavioral Screener
 SEAC- Special Education Advisory Council
 SIF- Social Innovation Fund
 SIM- State Innovation Model
 SLDS- Statewide Longitudinal Data System
 SMT- Strategic Management Team
 SNAP- Supplemental Nutrition Assistance Program
 SP- Suicide Prevention
 SPEAR- Hawaii's Suicide Prevention Education Action Resources
 SPIN- Special Parent Information Network
 SPM- Social and Preventative Medicine
 SPRC- Suicide Prevention Resource Center
 SPTF- Hawaii Suicide prevention Task Force
 SRTS- Safe Routes to School
 SSDI- State Systems Development Initiative
 TA- Technical assistance
 TAMC- Tripler Army Medical Center
 TANF- Temporary Assistance to Needy Families; TANF waiver referred to as PONO.
 TF- Task Force
 THF- Think Hawaii First program
 TOP- Teen Outreach Program
 TP- Teen Pregnancy
 TPEP- Tobacco Prevention and Education Program
 TPP- Teen Pregnancy Prevention
 UCLA - University of California Los Angeles

UHA- University Health Alliance
UHCDD- University of Hawaii's Center on Developmental Disabilities
UP- Unintended Pregnancies
USBC- United States Breastfeeding Coalition
USDA- United States Department of Agriculture
USDA-FNS- USDA Food and Nutrition Services
VAVR- Vaccine Administration Visit Record
VFC- Hawaii's Vaccine for Children Program
WBW- World Breastfeeding Week
WHCHC- West Hawaii Community Health Center
WHO- World Health Organization
WIC- Women, Infants and Children Service Branch
WSGSC- Western States Genetic Services Collaborative
YCA- Youth Challenge Academy
YCF- Youth Correctional Facility
YRBS- Youth Behavior Risk Survey
YSHCN- Youth with Special Health Care Needs
YTS- Youth Tobacco Survey

SPM 1 Telehealth: Data Collection Form 1 of 3

Infrastructure Performance Measures (Sustainability)

Use the scale below to rate the degree to which the following actions are used to promote the sustainability of the telehealth initiatives.

0	1	2	3	Element
				1. There is support for the MCHB-funded program or initiative within the parent agency or organization, including from individuals with planning and decision making authority.
				2. The program’s successes and identification of needs are communicated within and outside the organization among partners and the public, using various internal communication, outreach and marketing strategies.
				3. The organization identified, actively sought, and obtained other funding sources and in-kind resources to sustain the entire MCHB-funded program or initiative.
				4. Policies and procedures developed for the successful aspects of the program or initiative are incorporated into the parent or another organization’s system of programs and services.
				5. The responsibilities for carrying out key successful aspects of the program or initiative have begun to be transferred to permanent staff positions in other ongoing programs or organizations.
				6. The grantee has secured financial or in-kind support from within the parent organization or external organizations to sustain the <u>successful aspects</u> of the initiative.

0 = Not Met

1 = Partially Met

2 = Mostly Met

3 = Completely Met

Total the numbers in the boxes(max = 18): _____

SPM 1 Telehealth: Data Collection Form 2 of 3

Training Performance Measures

Numbers of individual recipients of telehealth training and technical assistance, by categories of target audiences:

(For each individual training or technical assistance activity, individual recipients or attendees should be, counted only once, in one audience category. Trainees who attended more than one training or received more than one type of TA activity should be counted once for each activity they received).

Families trained/provided TA	<input type="checkbox"/>	Yes	___# of individuals trained/provided TA
Other Consumers trained/provided TA	<input type="checkbox"/>	Yes	___# of individuals trained/provided TA
Health Providers/Professionals trained/provided TA	<input type="checkbox"/>	Yes	___# of individuals trained/provided TA
State MCH Agency Staff	<input type="checkbox"/>	Yes	___# of individuals trained/provided TA
Community based/Local organization staff trained/TA provided	<input type="checkbox"/>	Yes	___# of individuals trained/provided TA
Other (specify _____) trained/provided TA	<input type="checkbox"/>	Yes	___# of individuals trained/provided TA

Total number of individuals trained/provided TA from all audience types _____

SPM 1 Telehealth: Data Collection Form 3 of 3

Quality Improvement Measures

Use the scale described below to indicate the degree to which telehealth training has incorporated each of the design, evaluation, and continuous quality improvement activities into your training and TA work.

0	1	2	3	Element
Mechanisms in Place to Ensure Quality in Design of Training and TA Activities				
				<p>1. Build on Existing Information Resources and Expertise, and Ensure Up-to-Date Content. As part of the development of telehealth training and technical assistance services, activities (such as reviewing existing bibliographies, information resources, or other materials) to ensure that the information provided in newly developed training curricula and technical assistance materials and services is up to date with standard practice; based on research, evidence, and best practice-based literature; and is aligned with local, State, and/or Federal initiatives.</p>
				<p>2. Link to Other MCH Training and TA Activities. The training and TA provided is linked to the content and timing of training offered by other MCH grantees (e.g., Family-to-Family Health Information Centers, other national resource and training centers, State and local CSHCN/MCH programs).</p>
				<p>3. Obtain Input from the Target Audience to Ensure Relevancy to their Needs. Obtain input from the audience targeted for each training or TA activity before finalizing the curriculum or materials. This could include a determination of whether the content and language of the materials are relevant to the audience’s current needs and are understandable.</p>
				<p>4. Ensure Cultural and Linguistic Appropriateness. Employ mechanisms to ensure that training and TA materials, methods, and content are culturally and linguistically appropriate.</p>
Mechanisms in Place to Promote Grantee’s Training and Technical Assistance Services				
				<p>5. Conduct Outreach and Promotion to Ensure Target Audience is Aware of TA and Training Services. Use mechanisms to reach out to MCHB grantees and other target audiences such as provider or family organizations, consumers of MCH services, and the public, to make sure that target audiences know the services are available.</p>
Mechanisms in Place to Evaluate Training and TA Activities and Use the Data for Quality Improvement				
				<p>6. Collect Satisfaction Data. Use mechanisms, such as evaluation forms, to collect satisfaction data from recipients of training or TA.</p>
				<p>7. Collect Outcome Data. Collect data to assess whether recipients have increased their knowledge, leadership skills, and ability to apply new knowledge and skills to their family, health care practice, or other MCH program situation.</p>
				<p>8. Use Feedback for Quality Improvement. The degree to which the results of assessments or other feedback mechanisms are used to improve the content, reach and effectiveness of the training or TA activities.</p>

0=Not Met

1=Partially Met

2=Mostly Met

3=Completely Met

Total the numbers in the boxes (max= 24): _____

Service Performance Measures

	2017	2018	2019	2020	2021
Annual Objective					

0	1	2	3	Element
Family/Client Measures				
				1. Family/Client Satisfaction. Collect information from families/clients that receive services via telehealth to determine satisfaction with service provision.
				2. Family/Client Outcomes. Collect data to assess whether families/clients have increased their knowledge, ability to apply new knowledge and skills to use in their family.
				3. Cost and Time. Collect information about costs and time saved by families by using telehealth to receive services.
				4. Technology. Collect information about the quality of the connection and ease of use of the technology.
Provider Perception				
				1. Provider Satisfaction. Collect information from providers that provide services via telehealth to determine satisfaction with service provision.
				2. Cost and Time. Collect information about costs and time saved by providers by using telehealth to provide services.
				3. Technology. Collect information about the quality of the connection and ease of use of the technology.
Program Perception				
				1. Program Satisfaction. Collect information from programs to determine satisfaction with telehealth activities.
				2. Cost and Time. Collect information about costs saved by programs by using telehealth.
				3. Quality Improvement. Use of the data collected to develop and implement continuous quality improvement for the telehealth activities.

0=Not Met

1=Partially Met

2=Mostly Met

3=Completely Met

Total the numbers in the boxes (max=30): _____

VI. Organizational Chart

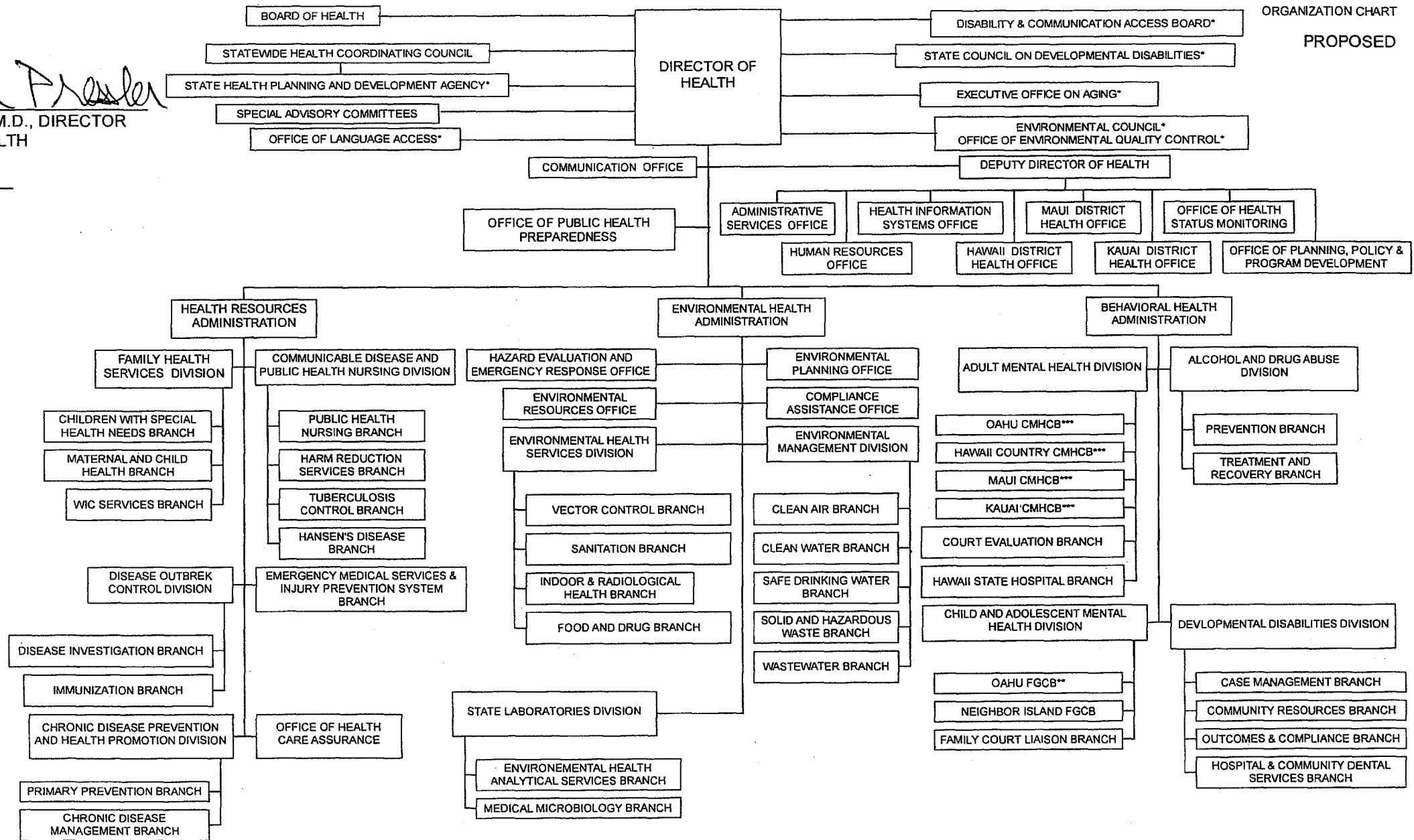
The Organizational Chart is uploaded as a PDF file to this section - [2017 org chart.pdf](#)

ORGANIZATION CHART
PROPOSED

ACKNOWLEDGED:

Virginia Pressler
VIRGINIA PRESSLER, M.D., DIRECTOR
DEPARTMENT OF HEALTH

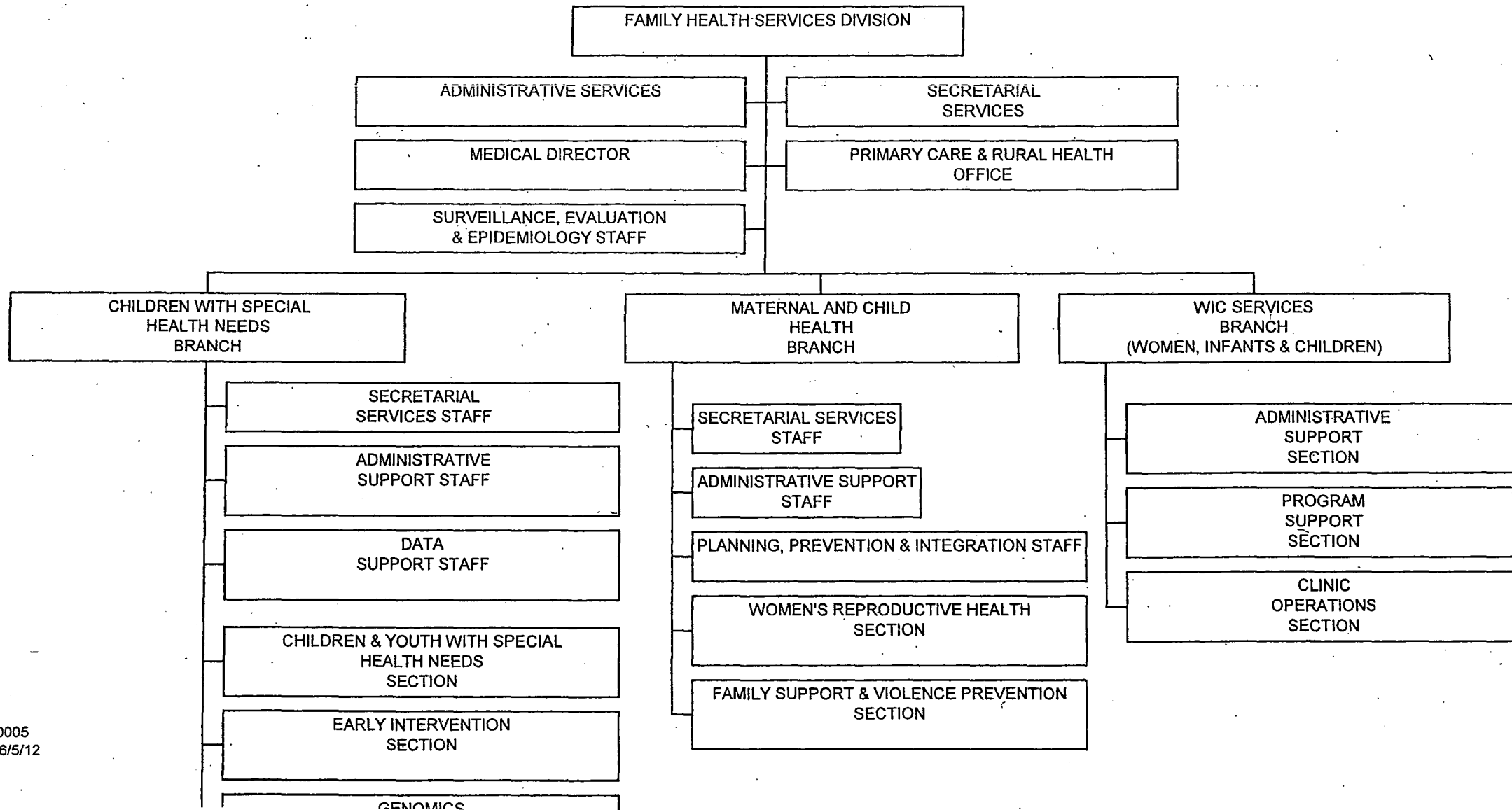
DATE: MAY 15 2018



ACT 262, 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.

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



VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Hawaii

	FY19 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 2,394,340	
A. Preventive and Primary Care for Children	\$ 728,721	(30.4%)
B. Children with Special Health Care Needs	\$ 776,638	(32.4%)
C. Title V Administrative Costs	\$ 68,095	(2.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 1,573,454	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 28,350,378	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 13,205,575	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 41,555,953	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 11,910,549		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 43,950,293	
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)	\$ 51,294,329	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 95,244,622	

OTHER FEDERAL FUNDS	FY19 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Program (CBCAP)	\$ 454,196
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 161,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 160,000
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) > State Oral Disease Prevention Program	\$ 250,000
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) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 12,969,228
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) > State Systems Development Initiative (SSDI)	\$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 29,760,334
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) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 2,157,300
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Health	\$ 172,000

OTHER FEDERAL FUNDS	FY19 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	\$ 400,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS)	\$ 426,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospital Improvement Program	\$ 93,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Medicare Rural Hospital Flexibility Program	\$ 419,316

	FY17 Annual Report Budgeted		FY17 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 2,176,627		\$ 1,998,893	
A. Preventive and Primary Care for Children	\$ 778,528	(35.8%)	\$ 626,838	(31.3%)
B. Children with Special Health Care Needs	\$ 761,805	(35%)	\$ 739,468	(36.9%)
C. Title V Administrative Costs	\$ 191,301	(8.8%)	\$ 38,229	(2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 1,731,634		\$ 1,404,535	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 29,083,184		\$ 24,722,002	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 75,000		\$ 47,719	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 16,745,817		\$ 10,892,484	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 45,904,001		\$ 35,662,205	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 11,910,549				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 48,080,628		\$ 37,661,098	
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)	\$ 55,420,856		\$ 44,210,716	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 103,501,484		\$ 81,871,814	

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Program (CBCAP)	\$ 454,196	\$ 259,334
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 34,210,089	\$ 32,239,362
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Genetic Services Project	\$ 600,000	\$ 482,129
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	\$ 426,600	\$ 92,715
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 161,000	\$ 170,234
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 255,086	\$ 279,283
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 40,000	\$ 29,831
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	\$ 250,000	\$ 272,175
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 196,772	\$ 99,141
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 100,000	\$ 97,686
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 2,247,675	\$ 2,159,899
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$ 12,969,228	\$ 4,742,315

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000	\$ 185,509
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 250,000	\$ 148,026
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 2,157,300	\$ 2,115,421
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Health	\$ 172,000	\$ 171,244
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	\$ 167,994	\$ 185,619
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Zika Surveillance Systems Grant Program		\$ 41,391
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Medicare Rural Hospital Flexibility Program	\$ 419,316	\$ 398,011
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospital Improvement Program	\$ 93,600	\$ 41,391

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	Field Name:	Federal Allocation, A. Preventive and Primary Care for Children:
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	The variance between FY 17 budgeted and Expended can be attributed to personnel vacancies.
2.	Field Name:	Federal Allocation, C. Title V Administrative Costs:
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	The variance between FY 17 budgeted and Expended can be attributed to personnel vacancies.
3.	Field Name:	3. STATE MCH FUNDS
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	The category "State MCH Funds" has was \$29,083,184 in fiscal year 2017, and the amount actually expended was \$24,722,002, a difference of \$4,361,182. This difference is attributed to outstanding unliquidated encumbrances as of September 30, 2017.
4.	Field Name:	5. OTHER FUNDS
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	The budgeted amount was \$75,000 in FY 17 but there were no actual expenditures due to the elimination of the Child Death Review Coordinator.
5.	Field Name:	6. PROGRAM INCOME
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	The amount budgeted for this category in fiscal year 2017 was \$16,745,817 and the amount actually expended was \$10,892,484. 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.

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	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	\$ 220,335	\$ 225,400
2. Infants < 1 year	\$ 265,728	\$ 245,592
3. Children 1 through 21 Years	\$ 728,721	\$ 626,838
4. CSHCN	\$ 776,638	\$ 739,468
5. All Others	\$ 334,823	\$ 123,366
Federal Total of Individuals Served	\$ 2,326,245	\$ 1,960,664

IB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	\$ 4,900,561	\$ 4,518,462
2. Infants < 1 year	\$ 3,328,028	\$ 3,295,111
3. Children 1 through 21 Years	\$ 6,881,604	\$ 3,750,193
4. CSHCN	\$ 21,116,619	\$ 19,219,139
5. All Others	\$ 5,329,141	\$ 4,879,300
Non-Federal Total of Individuals Served	\$ 41,555,953	\$ 35,662,205
Federal State MCH Block Grant Partnership Total	\$ 43,882,198	\$ 37,622,869

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Hawaii

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 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	\$ 133,392	\$ 128,447
3. Public Health Services and Systems	\$ 2,260,948	\$ 1,870,446
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	\$ 2,394,340	\$ 1,998,893

IIB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	\$ 22,642,658	\$ 19,366,339
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 1,832,576	\$ 1,598,036
B. Preventive and Primary Care Services for Children	\$ 8,403,429	\$ 6,949,495
C. Services for CSHCN	\$ 12,406,653	\$ 10,818,808
2. Enabling Services	\$ 10,440,228	\$ 9,009,725
3. Public Health Services and Systems	\$ 8,473,067	\$ 7,286,141
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 0
Physician/Office Services		\$ 1,412,655
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 1,171,920
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Other		
Primary and Urgent Care in Hana		\$ 1,075,773
Waianae Coast Emergency Room Services		\$ 1,755,775
Early Intervention Services (POS)		\$ 13,950,216
Direct Services Line 4 Expended Total		\$ 19,366,339
Non-Federal Total	\$ 41,555,953	\$ 35,662,205

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Hawaii

Total Births by Occurrence: 17,514

Data Source Year: 2017

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	17,432 (99.5%)	1,024	29	29 (100.0%)

Program Name(s)				
3-Hydroxy-3-methylglutaric aciduria	3-Methylcrotonyl-CoA carboxylase deficiency	Argininosuccinic aciduria	Biotinidase deficiency	Carnitine uptake defect/carnitine transport defect
Citrullinemia, type I	Classic galactosemia	Classic phenylketonuria	Congenital adrenal hyperplasia	Critical congenital heart disease
Cystic fibrosis	Glutaric acidemia type I	Glycogen Storage Disease Type II (Pompe)	Hearing loss	Holocarboxylase synthase deficiency
Homocystinuria	Isovaleric acidemia	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Maple syrup urine disease	Medium-chain acyl-CoA dehydrogenase deficiency
Methylmalonic acidemia (cobalamin disorders)	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Mucopolysaccharidosis Type 1	Primary congenital hypothyroidism	Propionic acidemia
S, βeta-Thalassemia	S,C disease	S,S disease (Sickle cell anemia)	Severe combined immunodeficiencies	β-Ketothiolase deficiency
Trifunctional protein deficiency	Tyrosinemia, type I	Very long-chain acyl-CoA dehydrogenase deficiency	X-linked Adrenoleukodystrophy	

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Children are monitored for at least a year or longer (up to 21 years old) if needed. Length of time depends on medical condition, health status of child, and social or other issues. This is done by the NBMS staff; CSHNB nurses, nutritionist, or social workers, or public health nurses.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

**Form 5a
Count of Individuals Served by Title V**

State: Hawaii

Annual Report Year 2017

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,307	68.3	0.0	13.6	16.6	1.5
2. Infants < 1 Year of Age	609	25.4	0.0	71.6	3.0	0.0
3. Children 1 through 21 Years of Age	15,832	28.3	0.0	69.0	2.7	0.0
3a. Children with Special Health Care Needs	7,330	23.0	0.0	11.3	0.6	65.1
4. Others	21,798	13.4	0.0	82.7	3.9	0.0
Total	39,546					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2017
	Field Note:	Programs that contributed to this count include pregnant women who received Perinatal Support Services (1,287) and Kauai District Health Office (20).
2.	Field Name:	Infants Less Than One YearTotal Served
	Fiscal Year:	2017
	Field Note:	Programs that contributed to this count of infants < 1 year of age include 2017 Primary Care Contracts (555), which are state funded for safely net providers including Federally Qualified Health Centers to provide services for the uninsured/underinsured. Additionally, there was no way to differentiate the primary source of coverage for those that were provided services through the underinsured due to lack of access to the data. Other programs that contributed to this count include Family Strengthening Programs [Community Based Parenting Education (41), home reach (13)]. Note. The percentages of primary source of coverage are based on 2016 Birth Certificate-Resident Live Births.
3.	Field Name:	Children 1 through 21 Years of Age
	Fiscal Year:	2017
	Field Note:	Programs that contributed to this count include 2017 Primary Care Contracts (2,741), which are state funded for safely net providers including Federally Qualified Health Centers to provide services for the uninsured/underinsured. Additionally, there was no way to differentiate the primary source of coverage for those that were provided services through the underinsured due to lack of access to the data. Other programs that contributed to this count include Family Planning Services (40% State Contribution; 1,860), Family Strengthening Programs [Children Exposed to Violence (3,613), Community Based Parenting Education (197), Home Reach (91)]. The count also included the number for Children with Special Health Care Needs in 3a (7,330). Note. The percentages of primary source of coverage are based on 2016 American Community Survey for children 1-21.
4.	Field Name:	Children with Special Health Care Needs
	Fiscal Year:	2017

Field Note:

3a. 2017 data for the number of children serviced contributed by CSHNP (7,330).

5.	Field Name:	Others
	Fiscal Year:	2017

Field Note:

Programs that contributed to this count of others include 2017 Primary Care Contracts (12,300), which are state funded for safely net providers including Federally Qualified Health Centers to provide services for the uninsured/underinsured. Additionally, there was no way to differentiate the primary source of coverage for those that were provided services through the underinsured due to lack of access to the data. The count also included Kauai District Office (36), Family Planning Services (40% State Contribution; 4,541), Family Strengthening Programs [Children Exposed to Violence (4,551), Community Based Parenting Education (82), Safe Sleep (265), Home Reach (23)] .

Note. The percentages of primary source of coverage are based on 2016 American Community Survey for adults 22+.

Data Alerts: None

Form 5b
Total Percentage of Populations Served by Title V

State: Hawaii

Annual Report Year 2017

Populations Served by Title V	Total % Served
1. Pregnant Women	48
2. Infants < 1 Year of Age	100
3. Children 1 through 21 Years of Age	12
3a. Children with Special Health Care Needs	17
4. Others	4

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women
	Fiscal Year:	2017
	Field Note:	Numerator : Programs that contributed to the numerator (8,406) included pregnant women who received Perinatal Support Services (1,287), Kauai District Health Office (20), the use of WIC Program during pregnancy estimated by 2015 PRAMS data (6,971; 39.8% of 2017 resident births), and Home Visiting Program (128). Denominator: Number of 2017 resident births=17,514
2.	Field Name:	Infants Less Than One Year
	Fiscal Year:	2017
	Field Note:	Estimated by percentage of newborn metabolic screening (99.5%)
3.	Field Name:	Children 1 Through 21 Years of Age
	Fiscal Year:	2017
	Field Note:	Numerator: Programs contributed to the numerator (41,117) included Primary Care Contracts (2,741), Family Planning Services (40% state contribution; 1,860), Home Visiting (381), Family Strengthening Programs [Children Exposed to Violence (3,613), Community Based Parenting Education (197), Parent Line (930), Home Reach (91)], Sexual Violence Prevention Program (2,963), Participation in WIC Program (aged 1-5; state provided administrative support, 20,245), Adolescent Health (766), and Children with Special Health Care Needs (7,330) Denominator: 2016 Census Estimate (356,924)
4.	Field Name:	Children With Special Health Care Needs
	Fiscal Year:	2017
	Field Note:	3a: The numerator was based on 2017 number of special health care needs children served by CSHNB (7,330). The denominator was based on the National Child Health survey 2016 for Hawaii age 0-17 (42,109).
5.	Field Name:	Others
	Fiscal Year:	2017
	Field Note:	Numerator: Programs contributed to the numerator (39,749) included Primary Care Contracts (12,300), Kauai District Health Office (36), Family Planning Services (40% state contribution; 4,541), Family Strengthening Programs [Children Exposed to Violence (4,551), Community Based Parenting Education (82), Safe Sleep (265), Parent Line (2,389), Home Reach (23)], Sexual Violence Prevention Program (15,538), and Adolescent Health (24). Denominator: 2016 Census Estimate (1,053,257)

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Hawaii

Annual Report Year 2017

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non- Hispanic White	(C) Non- Hispanic Black or African American	(D) Hispanic	(E) Non- Hispanic American Indian or Native Alaskan	(F) Non- Hispanic Asian	(G) Non- Hispanic Native Hawaiian or Other Pacific Islander	(H) Non- Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	17,159	3,293	379	2,631	14	4,528	1,642	4,517	155
Title V Served	17,071	3,276	377	2,617	14	4,505	1,634	4,494	154
Eligible for Title XIX	6,897	902	120	0	150	2,229	1,755	0	1,741
2. Total Infants in State	18,376	2,724	285	3,114	33	3,956	2,320	5,944	0
Title V Served	18,283	2,710	284	3,098	33	3,936	2,308	5,914	0
Eligible for Title XIX	9,343	135	38	0	38	439	153	0	8,540

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	Field Name:	1. Total Deliveries in State
	Fiscal Year:	2017
	Column Name:	Total
	Field Note:	Information obtained from maternal race as reported in 2017 vital statistics birth certificate data. The number of more than single birth (twin, triplet) is subtracted from the number of births.
2.	Field Name:	1. Title V Served
	Fiscal Year:	2017
	Column Name:	Total
	Field Note:	Used overall estimate of newborn metabolic screening percentage (99.5%) in 2017 applied to overall total and each race group.
3.	Field Name:	1. Eligible for Title XIX
	Fiscal Year:	2017
	Column Name:	Total
	Field Note:	Data Source: Data from Hawaii Medicaid program in 2017 and reflects unduplicated clients served Note: Data on ethnicity was not provided by the Hawaii Medicaid Program. The race groups might include both Hispanic and non-Hispanic origin. Note: Collection of race differs between that reported for Title V served and those reported for Title XIX so are not directly comparable. For example, the number of clients of more than one race was not provided by the Hawaii Medicaid Program.
4.	Field Name:	2. Total Infants in State
	Fiscal Year:	2017
	Column Name:	Total

Field Note:

Total number of infants based on 2016 CDC, NCHS, Bridged-Race population estimates from <https://wonder.cdc.gov>. 2017 information is not available yet. The Bridged-Race population groups reported are different from that requested in Title V. To determine race specific estimates for Title V, the distribution of race based on children under 5 years based on 2010 Census was applied to total infants in state as more current data was not available for requested race groups. Additionally, American Community Survey does not report out single year age estimates.

Note: Collection of race varies from that reported from vital statistics so not directly comparable. For example, more than one race reported was not available from data requested.

5. **Field Name:** **2. Title V Served**

Fiscal Year: **2017**

Column Name: **Total**

Field Note:

Based on the proportion of infants receiving newborn metabolic screening (99.5% in 2017)

6. **Field Name:** **2. Eligible for Title XIX**

Fiscal Year: **2017**

Column Name: **Total**

Field Note:

Data source: Data from Hawaii Medicaid program from 2017 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	2019 Application Year	2017 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 816-1222	(800) 816-1222
2. State MCH Toll-Free "Hotline" Name	The Parent Line	The Parent Line
3. Name of Contact Person for State MCH "Hotline"	Jodi Johnson	Jodi Johnson
4. Contact Person's Telephone Number	(808) 681-1541	(808) 681-1541
5. Number of Calls Received on the State MCH "Hotline"		2,389

B. Other Appropriate Methods	2019 Application Year	2017 Annual Report Year
1. Other Toll-Free "Hotline" Names	Early Intervention Referral Line	Early Intervention Referral Line
2. Number of Calls on Other Toll-Free "Hotlines"		3,565
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 2019

No.	Priority Need
1.	Promote reproductive life planning
2.	Reduce the rate of infant mortality
3.	Improve the percentage of children screened early and continuously age 0-5 years for developmental delay
4.	Reduce the rate of child abuse and neglect with special attention on ages 0-5 years.
5.	Improve the percentage of youth with special health care needs ages 12-21 years who receive services necessary to make transitions to adult health care.
6.	Improve the oral health of children
7.	Improve the healthy development, health, safety, and well-being of adolescents
8.	Improve access to services through telehealth

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Promote reproductive life planning	Continued	
2.	Reduce the rate of infant mortality	New	
3.	Improve the percentage of children screened early and continuously age 0-5 years for developmental delay	Continued	
4.	Reduce the rate of child abuse and neglect with special attention on ages 0-5 years.	Continued	
5.	Improve the percentage of youth with special health care needs ages 14-21 years who receive services necessary to make transitions to adult health care.	Continued	
6.	Improve the oral health of children and pregnant women.	Continued	
7.	Improve the healthy development, health, safety, and well-being of adolescents	New	
8.	Improve access to services through telehealth	New	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

**Form 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
2016	75.9 %	0.3 %	13,232	17,426
2015	77.2 %	0.3 %	13,650	17,680
2014	77.9 %	0.3 %	13,696	17,578

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	126.6	10.6	144	11,376
2014	135.7	9.5	205	15,112
2013	101.2	8.1	157	15,516
2012	106.8	8.3	167	15,632
2011	77.7	7.1	121	15,567
2010	44.9	5.4	70	15,585
2009	54.4	5.9	86	15,817
2008	49.9	5.6	81	16,225

Legends:

- Indicator has a numerator ≤ 10 and is not reportable
- Indicator has a numerator < 20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

FAD Not Available for this measure.

State Provided Data	
	2017
Annual Indicator	13.1
Numerator	12
Denominator	91,597
Data Source	Vital Statistics
Data Source Year	2013-2017

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. 2017 data is provisional

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	8.5 %	0.2 %	1,537	18,045
2015	8.3 %	0.2 %	1,531	18,392
2014	7.9 %	0.2 %	1,462	18,526
2013	8.2 %	0.2 %	1,562	18,970
2012	8.1 %	0.2 %	1,542	18,975
2011	8.2 %	0.2 %	1,557	18,947
2010	8.4 %	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 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	10.6 %	0.2 %	1,904	18,053
2015	10.1 %	0.2 %	1,861	18,409
2014	10.0 %	0.2 %	1,862	18,537
2013	10.2 %	0.2 %	1,928	18,959
2012	9.9 %	0.2 %	1,885	18,964
2011	9.9 %	0.2 %	1,880	18,938
2010	10.5 %	0.2 %	1,985	18,953
2009	11.2 %	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 - 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
2016	27.8 %	0.3 %	5,022	18,053
2015	27.9 %	0.3 %	5,140	18,409
2014	27.6 %	0.3 %	5,115	18,537
2013	26.5 %	0.3 %	5,024	18,959
2012	26.4 %	0.3 %	5,012	18,964
2011	27.0 %	0.3 %	5,104	18,938
2010	26.9 %	0.3 %	5,089	18,953
2009	28.4 %	0.3 %	5,326	18,785

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, 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
2016/Q2-2017/Q1	1.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	6.0 %			
2013/Q2-2014/Q1	7.0 %			

Legends:
 Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	4.9	0.5	90	18,452
2014	5.0	0.5	93	18,591
2013	6.7	0.6	128	19,038
2012	5.4	0.5	103	19,028
2011	6.1	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
2015	5.7	0.6	105	18,420
2014	4.5	0.5	83	18,550
2013	6.4	0.6	121	18,987
2012	4.9	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
2015	3.6	0.5	67	18,420
2014	3.3	0.4	62	18,550
2013	4.6	0.5	87	18,987
2012	3.6	0.4	68	18,980
2011	3.6	0.4	68	18,956
2010	4.0	0.5	76	18,988
2009	4.4	0.5	83	18,887

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.1	0.3	38	18,420
2014	1.1	0.3	21	18,550
2013	1.8	0.3	34	18,987
2012	1.3	0.3	24	18,980
2011	1.7	0.3	32	18,956
2010	2.2	0.3	42	18,988
2009	1.5	0.3	29	18,887

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	228.0	35.2	42	18,420
2014	177.9	31.0	33	18,550
2013	258.1	36.9	49	18,987
2012	200.2	32.5	38	18,980
2011	200.5	32.6	38	18,956
2010	221.2	34.2	42	18,988
2009	233.0	35.2	44	18,887

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	76.0 ⚡	20.3 ⚡	14 ⚡	18,420 ⚡
2014	NR 🚩	NR 🚩	NR 🚩	NR 🚩
2013	79.0 ⚡	20.4 ⚡	15 ⚡	18,987 ⚡
2012	63.2 ⚡	18.3 ⚡	12 ⚡	18,980 ⚡
2011	NR 🚩	NR 🚩	NR 🚩	NR 🚩
2010	115.9	24.7	22	18,988
2009	NR 🚩	NR 🚩	NR 🚩	NR 🚩

Legends:

- 🚩 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None



Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	8.7 %	1.0 %	1,522	17,555
2014	8.5 %	1.0 %	1,474	17,402
2013	7.6 %	0.9 %	1,368	18,029
2012	7.9 %	0.9 %	1,416	17,864
2011	6.9 %	0.8 %	1,267	18,437
2010	7.2 %	0.8 %	1,328	18,461
2009	6.7 %	0.8 %	1,230	18,374
2008	6.3 %	0.6 %	1,167	18,459
2007	6.0 %	0.6 %	1,107	18,342

Legends:

-  Indicator has an unweighted denominator <30 and is not reportable
-  Indicator has an unweighted denominator between 30 and 59 or 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 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	NR 	NR 	NR 	NR 
2014	1.4	0.3	22	15,358
2013	0.8 	0.2 	12 	15,722 
2012	0.8 	0.2 	13 	15,869 
2011	0.8 	0.2 	13 	15,757 
2010	NR 	NR 	NR 	NR 
2009	NR 	NR 	NR 	NR 
2008	0.8 	0.2 	13 	16,419 

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 year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	10.9 %	1.4 %	32,106	295,883

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	16.9	3.2	27	160,245
2015	14.4	3.0	23	160,241
2014	14.5	3.0	23	158,910
2013	20.2	3.6	32	158,268
2012	10.9 ⚡	2.7 ⚡	17 ⚡	155,558 ⚡
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
- ⚡ 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
2016	33.7	4.6	54	160,416
2015	27.0	4.1	44	163,073
2014	20.9	3.6	34	162,896
2013	25.2	3.9	41	162,519
2012	27.7	4.1	45	162,427
2011	30.3	4.3	50	165,114
2010	26.9	4.0	45	167,533
2009	31.5	4.3	53	168,494

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	10.9	2.1	26	238,506
2013_2015	9.6	2.0	23	240,137
2012_2014	8.3	1.9	20	242,273
2011_2013	11.4	2.2	28	245,750
2010_2012	11.1	2.1	28	251,412
2009_2011	12.5	2.2	32	256,302
2008_2010	11.6	2.1	30	259,537
2007_2009	10.8	2.0	28	260,274

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None



Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	13.0	2.3	31	238,506
2013_2015	11.2	2.2	27	240,137
2012_2014	8.3	1.9	20	242,273
2011_2013	9.0	1.9	22	245,750
2010_2012	9.6	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 (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	13.6 %	1.3 %	42,109	309,692

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	16.7 %	3.2 %	7,021	42,109

Legends:

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	1.8 % ⚡	0.6 % ⚡	4,558 ⚡	257,036 ⚡

Legends:

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	5.0 %	0.7 %	12,754	254,397

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	38.4 % ⚡	7.4 % ⚡	8,494 ⚡	22,150 ⚡

Legends:

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	91.7 %	1.2 %	282,105	307,798

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	10.3 %	0.3 %	1,343	12,987
2012	10.2 %	0.3 %	1,489	14,578
2010	9.7 %	0.3 %	1,413	14,504
2008	10.0 %	0.3 %	1,279	12,796

Legends:

- Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable
- Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	12.9 %	1.1 %		
2013	13.4 %	1.0 %		
2011	13.2 %	1.2 %		
2009	14.2 %	1.7 %		
2007	15.2 %	1.4 %		
2005	13.1 %	1.0 %		

Legends:

- Indicator has an unweighted denominator <100 and is not reportable
- Indicator has a confidence interval width >20% and should be interpreted with caution


Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	11.0 %	1.9 %	12,738	115,773

Legends:

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None



Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	2.1 %	0.4 %	6,484	306,799
2015	1.4 %	0.3 %	4,350	312,071
2014	2.0 %	0.3 %	6,246	307,392
2013	3.2 %	0.6 %	9,896	306,669
2012	2.9 %	0.5 %	8,844	301,575
2011	3.9 %	0.6 %	11,813	304,365
2010	3.7 %	0.6 %	11,134	302,473
2009	2.6 %	0.5 %	7,498	288,177

Legends:

-  Indicator has an unweighted denominator <30 and is not reportable
-  Indicator has a confidence interval width 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
2016	75.1 %	3.1 %	19,930	26,535
2015	73.8 %	3.2 %	19,173	25,966
2014	73.7 %	3.3 %	19,437	26,371
2013	66.5 %	4.2 %	17,471	26,291
2012	80.2 %	2.8 %	21,101	26,326
2011	74.8 %	3.7 %	20,233	27,044
2010	63.7 %	3.3 %	17,732	27,823
2009	46.7 %	3.9 %	12,642	27,068

Legends:

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	60.6 %	2.2 %	169,771	280,243
2015_2016	71.8 %	2.0 %	198,006	275,967
2014_2015	74.4 %	1.9 %	206,844	278,016
2013_2014	70.4 %	2.6 %	194,717	276,586
2012_2013	69.7 %	3.3 %	199,548	286,207
2011_2012	66.6 %	4.0 %	178,392	267,854
2010_2011	70.0 % ⚡	6.4 % ⚡	181,808 ⚡	259,726 ⚡
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
- ⚡ 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
2016	71.7 %	4.4 %	28,004	39,042
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
2016	58.3 %	4.5 %	23,916	41,034
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
2016	82.2 %	2.6 %	65,799	80,076
2015	79.6 %	2.5 %	63,034	79,172
2014	82.3 %	2.5 %	66,040	80,260
2013	80.2 %	2.7 %	64,200	80,038
2012	74.1 %	3.0 %	61,021	82,379
2011	67.7 %	3.2 %	56,199	83,036
2010	58.1 %	3.2 %	47,269	81,309
2009	46.1 %	3.5 %	36,222	78,650

Legends:

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
-  Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None



Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	75.9 %	2.9 %	60,738	80,076
2015	78.7 %	2.5 %	62,278	79,172
2014	77.7 %	2.7 %	62,358	80,260
2013	75.0 %	3.1 %	60,003	80,038
2012	70.4 %	3.2 %	58,019	82,379
2011	70.2 %	3.0 %	58,282	83,036
2010	64.5 %	3.0 %	52,417	81,309
2009	51.0 %	3.5 %	40,094	78,650

Legends:

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
-  Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	19.2	0.7	728	37,877
2015	20.7	0.7	789	38,123
2014	23.3	0.8	893	38,413
2013	25.0	0.8	976	39,000
2012	27.9	0.8	1,108	39,717
2011	29.7	0.9	1,199	40,367
2010	32.6	0.9	1,347	41,288
2009	37.1	0.9	1,547	41,755

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	9.0 %	1.1 %	1,610	17,938
2014	11.0 %	1.2 %	1,974	17,970
2013	9.5 %	1.0 %	1,748	18,407
2012	10.6 %	1.0 %	1,938	18,254

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	2.7 %	0.8 %	8,400	307,347

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)
State: Hawaii

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

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	67.0	68.0	69.0	70.0	70.0	71.0

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2018
	Column Name:	Annual Objective

Field Note:

The annual performance objective for years 2018-2023 reflects an approximate 5% improvement over 5 years distributed among the individual years.

NPM 4A - Percent of infants who are ever breastfed

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	89.0	90.0	91.0	91.0	92.0	92.0

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2018
	Column Name:	Annual Objective

Field Note:

The annual performance objective for years 2018-2023 reflects an approximate 5% improvement over 5 years distributed among the individual years.

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

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	30.0	31.0	31.0	32.0	32.0	32.0

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2018
	Column Name:	Annual Objective

Field Note:

The annual performance objective for years 2018-2023 reflects an approximate 5% improvement over 5 years distributed among the individual years.

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

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	80.0	81.0	82.0	83.0	84.0	85.0

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2018
	Column Name:	Annual Objective

Field Note:

The annual performance objective for years 2018-2023 reflects an approximate 5% improvement over 5 years distributed among the individual years.

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

FAD for this measure is not available for the State.

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

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

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	1 is entered because PRAMS 2016 data is not available in State
2.	Field Name:	2019
	Column Name:	Annual Objective
	Field Note:	1 is entered because data is not available in State

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

FAD for this measure is not available for the State.

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

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

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	1 is entered because PRAMS 2016 data is not available in State
2.	Field Name:	2019
	Column Name:	Annual Objective
	Field Note:	1 is entered because data is not available in State

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	2017
Annual Objective		
Annual Indicator		32.0
Numerator		12,946
Denominator		40,486
Data Source		NSCH
Data Source Year		2016

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	33.0	33.0	33.0	33.0	34.0	34.0

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2018
	Column Name:	Annual Objective

Field Note:

The annual performance objective for years 2018-2023 reflects an approximate 5% improvement over 5 years distributed among the individual years.

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

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	2017
Annual Objective		
Annual Indicator		73.5
Numerator		67,325
Denominator		91,592
Data Source		NSCH
Data Source Year		2016

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	74.0	74.0	75.0	76.0	77.0	77.0

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2018
	Column Name:	Annual Objective

Field Note:

The annual performance objective for years 2018-2023 reflects an approximate 5% improvement over 5 years distributed among the individual years.

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	2017
Annual Objective		
Annual Indicator		23.3
Numerator		4,235
Denominator		18,144
Data Source		NSCH-CSHCN
Data Source Year		2016

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	23.0	23.0	23.0	24.0	24.0	25.0

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2018
	Column Name:	Annual Objective

Field Note:

The annual performance objective for years 2018-2023 reflects an approximate 5% improvement over 5 years distributed among the individual years.

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	2017
Annual Objective		
Annual Indicator		83.1
Numerator		243,681
Denominator		293,312
Data Source		NSCH
Data Source Year		2016

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	84.0	85.0	86.0	87.0	87.0	88.0

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2018
	Column Name:	Annual Objective

Field Note:

The annual performance objective for years 2018-2023 reflects an approximate 5% improvement over 5 years distributed among the individual years.

**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	2017
Annual Objective		
Annual Indicator		
Numerator	8	11
Denominator	72	72
Data Source	Telehealth work group, Family Health Services Divi	The preliminary 5-year plan objectives were develo
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	11.0	11.0	11.0	12.0	12.0	12.0

Field Level Notes for Form 10a SPMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	The measure is a scale. Converting into percentages the annual indicator would be $8/72 = 11.1\%$
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	The measure is a scale. Converting into percentages the annual indicator would be $11/72 = 15.3\%$
3.	Field Name:	2018
	Column Name:	Annual Objective
	Field Note:	The measure is a scale. Converting into percentages the annual objective for 2018-2010 would be $11/72 = 15.3\%$, and 2021-2023 would be $12/72 = 16.7\%$

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

Measure Status: Inactive - Integrated into other measures rather than stand alone SPM

State Provided Data		
	2016	2017
Annual Objective		29
Annual Indicator	23.9	23.9
Numerator	11	11
Denominator	46	46
Data Source	FHSD Staff Survey	FHSD Staff Survey
Data Source Year	2016	2016
Provisional or Final ?	Final	Provisional

Field Level Notes for Form 10a SPMs:

1.	Field Name:	2017
	Column Name:	State Provided Data

Field Note:
No updated data available

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

Measure Status:	Inactive - Integrated into other measures rather than stand alone SPM
------------------------	--

State Provided Data		
	2016	2017
Annual Objective		18
Annual Indicator	13	13
Numerator	6	6
Denominator	46	46
Data Source	FHSD Staff survey	FHSD Staff survey
Data Source Year	2016	2016
Provisional or Final ?	Final	Provisional

Field Level Notes for Form 10a SPMs:

1.	Field Name:	2017
	Column Name:	State Provided Data

Field Note:
Updated data not available

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

Measure Status:	Active
------------------------	---------------

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	6.0	5.9	5.9	5.8	5.8

Field Level Notes for Form 10a SPMs:

1.	Field Name:	2019
	Column Name:	Annual Objective

Field Note:

Baseline Data from 2017 DHS CAN annual report represents a rate of 6.1 per 1,000 children 0-5 years of age (N=635 unique children confirmed victims). Objectives set at 5% improvement over 5 years spread out over individual years.

**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	2017
Annual Objective		34
Annual Indicator	32.7	31.8
Numerator	3,020	2,851
Denominator	9,237	8,975
Data Source	vital statistics	vital statistics
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	31.0	31.0	30.0	30.0	30.0	30.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2016
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	Column Name:	State Provided Data
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Field Note:
Estimate for 2016 revised due to availability of 2016 data; prior year reported 2015 provisional only.

2.	Field Name:	2017
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	Column Name:	State Provided Data
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Field Note:
Estimate based on 2017 provisional vital statistics data file as final 2017 data file not available.

3.	Field Name:	2018
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	Column Name:	Annual Objective
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Field Note:
The annual performance objective for years 2018-2023 reflects an approximate 5% improvement over 5 years distributed among the individual years.

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

Measure Status:	Active
------------------------	---------------

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	81.0	82.0	83.0	84.0	85.0	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:	State Provided Data
	Field Note:	Due to changes in data collection system over the transition completed in May 2017, no comparable data was available to report with this ESM so the 2016 data was carried over to 2017.
3.	Field Name:	2018
	Column Name:	Annual Objective
	Field Note:	The annual performance objective for years 2018-2023 reflects an approximate 5% improvement over 5 years distributed among the individual years.

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

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

- Field Name:** 2017

Column Name: State Provided Data

Field Note:

- Field Name:** 2018

Column Name: Annual Objective

Field Note:

Objectives were set at 100% for period 2018-2023

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

Measure Status:	Inactive - Completed
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State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	No	Yes
Numerator		
Denominator		
Data Source	Program Data	Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Field Level Notes for Form 10a ESMs:

None

ESM 6.2 - Develop and Implement Policy and Public Health Coordination (PPHC) rating scale to monitor infrastructure development within FHSD.

Measure Status:	Active
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Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	12.0	18.0	24.0	27.0	30.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2019
	Column Name:	Annual Objective

Field Note:

Baseline Scale set at 9. Objectives set by program to reach max scale score of 30 over 5 years.

ESM 10.1 - Development and dissemination of a teen-centered, Adolescent Resource Toolkit (ART) with corresponding continuing education series (Science) to primary care providers to increase knowledge and skill in implementing the adolescent well-care visit

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator		
Numerator	13	16
Denominator	51	51
Data Source	ART and Science Workgroup	ART and Science Workgroup
Data Source Year	2016 PRog	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	16.0	19.0	22.0	25.0	30.0	35.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2018
	Column Name:	Annual Objective

Field Note:

Objectives set by program to reach score of 35 (out of 51 possible) over 5 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
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State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator		
Numerator	12	13
Denominator	33	33
Data Source	Title V Transition Workgroup	Title V Transition Workgroup
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	17.0	21.0	25.0	27.0	27.0	27.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	The measure is a scale and the annual indicator for 2017 is 13. Converting into percentage $13/33 = 39.4\%$
2.	Field Name:	2018
	Column Name:	Annual Objective
	Field Note:	The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2018 objective will be $17/33 = 51.5\%$.
3.	Field Name:	2019
	Column Name:	Annual Objective
	Field Note:	The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2019 objective will be $21/33 = 63.6\%$.
4.	Field Name:	2020
	Column Name:	Annual Objective
	Field Note:	The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2020 objective will be $25/33 = 75.8\%$.
5.	Field Name:	2021
	Column Name:	Annual Objective
	Field Note:	The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2021 objective will be $27/33 = 81.8\%$.
6.	Field Name:	2022
	Column Name:	Annual Objective
	Field Note:	The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2022 objective will be $27/33 = 81.8\%$.
7.	Field Name:	2023
	Column Name:	Annual Objective
	Field Note:	The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2023 objective will be $27/33 = 81.8\%$.

ESM 13.2.1 - The establishment of leadership for the State Oral Health Program under the direction of a dental professional and staff with public health skills.

Measure Status:	Inactive - Completed
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State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	No	Yes
Numerator		
Denominator		
Data Source	State Oral Health Program, Family Health Svcs Div	State Oral Health Program, Family Health Svcs Div
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Field Level Notes for Form 10a ESMs:

None

ESM 13.2.2 - Completion of teledentistry pilot project at three early childhood settings to reach underserved children.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	No	No
Numerator		
Denominator		
Data Source	Virtual Dental Home Planning Team	Virtual Dental Home Planning Team
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2018
	Column Name:	Annual Objective

Field Note:

Objectives were set to Yes for period 2018-2023

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/Systems Building

Measure Status:	Active								
Goal:	Increase the use of telehealth across Title V activities to improve access to services and education for families and providers.								
Definition:	<table border="1" style="width: 100%;"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Total Actual Scores from three Telehealth Data Collection Forms</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Total Possible Scores from three Telehealth Data Collection Forms (18, 24, 30)</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Scale</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>72</td> </tr> </table>	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
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:	<p>This is a summary of the Data Collection Form that lists 24 strategy components organized by the three areas in telehealth activities:</p> <ul style="list-style-type: none"> • Infrastructure development • Training/education development • Service development <p>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.</p>								
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/Systems Building

Measure Status:	Inactive - Integrated into other measures rather than stand alone SPM								
Goal:	Increase the engagement of families and consumers in FHSD activities.								
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>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</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Total number of staff selected to be part of Title V Planning asked: 46</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>100</td> </tr> </table>	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
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:	<p>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.</p> <p>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.</p> <p>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.</p>								
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								

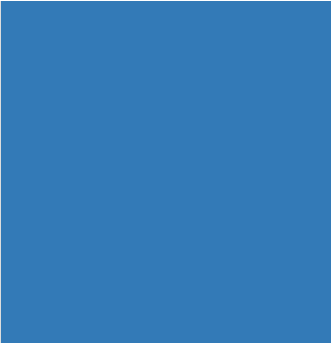


increased responsiveness to federal requirements (Title V Tip Sheet: Lessons Learned from MCH & CSHCN Directors, 2002). Engaging families and consumers at various levels – policy and advocacy, program improvement, and public awareness and promotion – can lead to mutually strengthening and supportive 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/Systems Building

Measure Status:	Inactive - Integrated into other measures rather than stand alone SPM								
Goal:	Increase the meaningful engagement of partners in FHSD activities.								
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>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</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Total number of staff selected to be part of Title V Planning asked: 46</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>100</td> </tr> </table>	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
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:	<p>Although 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.</p> <p>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.</p> <p>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.</p>								
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.

SPM 4 - Rate of confirmed and child abuse and neglect reports per 1,000 for children aged 0 to 5 years.
Population Domain(s) – Child Health

Measure Status:	Active								
Goal:	Reduce the rate of child abuse and neglect with special attention on ages 0-5 years.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of confirmed Child Protective Services reports of abuse and neglect for children aged 0 to 5 years</td> </tr> <tr> <td>Denominator:</td> <td>Number of children aged 0 to 5 years in the state based on decennial census (2010 data reported 104,333 children)</td> </tr> <tr> <td>Unit Type:</td> <td>Rate</td> </tr> <tr> <td>Unit Number:</td> <td>1,000</td> </tr> </table>	Numerator:	Number of confirmed Child Protective Services reports of abuse and neglect for children aged 0 to 5 years	Denominator:	Number of children aged 0 to 5 years in the state based on decennial census (2010 data reported 104,333 children)	Unit Type:	Rate	Unit Number:	1,000
Numerator:	Number of confirmed Child Protective Services reports of abuse and neglect for children aged 0 to 5 years								
Denominator:	Number of children aged 0 to 5 years in the state based on decennial census (2010 data reported 104,333 children)								
Unit Type:	Rate								
Unit Number:	1,000								
Healthy People 2020 Objective:	<p>Related to: IPV-37 Reduce child maltreatment deaths to 2.1 deaths per 100,000 children under age 18 years. Baseline: 2.3 child maltreatment deaths per 100,000 children under age 18 years occurred in 2008.</p> <p>IPV-38: Reduce nonfatal child maltreatment to 8.5 maltreatment victims per 1,000 children under age 18 years. Baseline: 9.4 victims of nonfatal child maltreatment per 1,000 children under age 18 years were reported in 2008.</p>								
Data Sources and Data Issues:	Hawaii Department of Human Services, Management Services Office. Child Abuse and Neglect Annual reports								
Significance:	Child abuse and neglect has pervasive effects over a person's lifetime. Abuse has negative effects not only on physical health but also on mental, emotional and social health of individuals.								

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, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active								
Goal:	To support reproductive life planning and healthy birth outcomes by increasing intervals of birth spacing (births spaced from 18 month to next conception).								
Definition:	<table border="1" style="width: 100%;"> <tr> <td style="background-color: #4F81BD; color: white;">Numerator:</td> <td>Number of Births with interval < 18 months between birth and next conception</td> </tr> <tr> <td style="background-color: #4F81BD; color: white;">Denominator:</td> <td>Total number of Births</td> </tr> <tr> <td style="background-color: #4F81BD; color: white;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #4F81BD; color: white;">Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of Births with interval < 18 months between birth and next conception	Denominator:	Total number of Births	Unit Type:	Percentage	Unit Number:	100
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:	<p>Data source is vital statistics, Office of Health Status Monitoring.</p> <p>Calculation of interval is based on birth certificate data with valid clinical estimate of gestational age of index birth and prior live birth.</p> <p>Pregnancy Interval = ConceptionDate – Last Live Birth (following HRSA ColIN to reduce infant mortality outcome measure).</p>								
Significance:	<p>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 Medicare 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®.</p>								

ESM 4.1 - Percent of Women, Infants, and Children (WIC) infants ever breastfed
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active	
Goal:	Promote Breastfeeding in all WIC clinics statewide	
Definition:	Numerator:	Unduplicated number of WIC infants ever breastfed by SFY
	Denominator:	Unduplicated number of WIC infants by SFY
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	Hawaii WIC Program Data	
Significance:	<p>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).</p>	
	<p>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.</p>	
	<p>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.</p>	

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


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

Measure Status:	Active								
Goal:	Educate mother and family to maintain a safe sleep position & environment for infants.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of birthing hospitals with current AAP safe sleep protocols</td> </tr> <tr> <td>Denominator:</td> <td>Total number of birthing hospitals</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of birthing hospitals with current AAP safe sleep protocols	Denominator:	Total number of birthing hospitals	Unit Type:	Percentage	Unit Number:	100
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:	<p>About 3,500 US infants die suddenly and unexpectedly each year. These 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).</p> <p>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.</p> <p>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.</p>								

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 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Inactive - Completed								
Goal:	Increase the number of children receiving developmental screening, being referred and receiving services among Hawaii Title V direct service programs.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>N/A</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Text</td> </tr> <tr> <td>Unit Number:</td> <td>Yes/No</td> </tr> </table>	Numerator:	N/A	Denominator:	N/A	Unit Type:	Text	Unit Number:	Yes/No
Numerator:	N/A								
Denominator:	N/A								
Unit Type:	Text								
Unit Number:	Yes/No								
Data Sources and Data Issues:	<p>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.</p> <p>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.</p>								
Significance:	<p>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 incompleteness of the establishment of a data sharing system.</p> <p>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</p>								



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 6.2 - Develop and Implement Policy and Public Health Coordination (PPHC) rating scale to monitor infrastructure development within FHSD.

NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active								
Goal:	Increase the number of children receiving developmental screening and referred and receiving services among Hawaii Title V direct service programs.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Total scale score based on program assessment of 10 steps</td> </tr> <tr> <td>Denominator:</td> <td>30</td> </tr> <tr> <td>Unit Type:</td> <td>Scale</td> </tr> <tr> <td>Unit Number:</td> <td>30</td> </tr> </table>	Numerator:	Total scale score based on program assessment of 10 steps	Denominator:	30	Unit Type:	Scale	Unit Number:	30
Numerator:	Total scale score based on program assessment of 10 steps								
Denominator:	30								
Unit Type:	Scale								
Unit Number:	30								
Data Sources and Data Issues:	Program Data. The ESM 6.2 is using the Hawaii Title V Developmental Screening Workgroup's Policy and Public Health Coordination (PPHC) rating scale to monitor infrastructure development on developmental screening and services within FHSD. It will be a self-assessment of the team's efforts to improve efforts to develop the infrastructure for FHSD screening and services and will be measured annually.								
Significance:	<p>The PPHC will help measure Hawaii's efforts to improve the service delivery and systems development for developmental screening with the end goal of all the strategies and activities completion will signify that the system has been developed. A Policy and Public Health Coordination Scale (PPHCS) has been created to monitor/track progress made on the 5-Year plan strategies for developmental screening. The Title V Screening Workgroup will complete the scale annually starting in FFY 2019 as part of routine evaluation.</p> <p>Element 0 --Not met 1--Partially Met 2--Mostly Met 3--Completely Met</p> <p>Systems Development</p> <ol style="list-style-type: none"> 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. <p>Family Engagement and Public Awareness</p> <ol style="list-style-type: none"> 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. <p>Data Integration</p> <ol style="list-style-type: none"> 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 <p>Policy and Public Health Coordination</p> <ol style="list-style-type: none"> 7. Develop Policy and Public Health Coordination Scale. 8. Conduct process for annual assessment of rating scale. <p>Social Determinants of Health and Vulnerable Populations</p> <ol style="list-style-type: none"> 9. Develop process for identifying vulnerable populations. 10. Work with stakeholders to address supports and targeted interventions for vulnerable populations 								

ESM 10.1 - Development and dissemination of a teen-centered, Adolescent Resource Toolkit (ART) with corresponding continuing education series (Science) to primary care providers to increase knowledge and skill in implementing the adolescent well-care visit

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

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:	<table border="1"> <tr> <td style="background-color: #2c5e8c; color: white;">Numerator:</td> <td>Numerator: Total Actual Score from Adolescent Health Data Collection Form</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Denominator:</td> <td>Denominator: Total Possible Score from Adolescent Health Data Collection Form</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Unit Type:</td> <td>Scale</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Unit Number:</td> <td>51</td> </tr> </table>	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
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:	<p>This is a summary of the Data Collection Form that lists 17 strategy components organized by the following domains:</p> <ul style="list-style-type: none"> • Adolescent Resource Toolkit • Continuing Education Curriculum Series (Science) • Outreach and Training <p>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.</p>								
Significance:	<p>Many health plan, provider, parent and adolescent challenges exist which limit access to comprehensive adolescent well care (AWC) visits which include:</p> <ul style="list-style-type: none"> • 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 AWC • Inconsistent practices addressing confidentiality • Provider discomfort with mental health, substance abuse, and reproductive health interventions • Lack of knowledge of community resources <p>Teen-centered care includes:</p> <ul style="list-style-type: none"> • 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, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active								
Goal:	To increase the degree to which the Title V CYSHNS promotes and/or facilitates transition to adult health care for YSHCN.								
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Total Actual Score from Transition to Adult Health Care Data Collection Form</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Total Possible Score from Transition to Adult Health Care Data Collection Form (33)</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Scale</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>33</td> </tr> </table>	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
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:	<p>This is a summary of the Data Collection Form that lists 11 strategy components organized by the Six Core Elements of Health Care Transition:</p> <ul style="list-style-type: none"> • Transition policy • Transition tracking and monitoring • Transition readiness • Transition planning • Transfer of care • Transition completion. <p>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.</p>								
Significance:	<p>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.</p> <p>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.</p> <p>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</p>								

(AAFP), and American College of Physicians (ACP). References: Got Transition, "Side-By-Side Version, Six Core Elements of Health Care Transition 2.0"; AAP, AAFP, ACP, "Clinical Report – Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home", Pediatrics 2011;128:182-200; McPheeters M et al., "Transition Care for Children With Special Health Needs", Technical Brief No. 15. Agency for Healthcare Research and Quality (AHRQ) Publication No. 14-EHC027-EF, June 2014.

ESM 13.2.1 - The establishment of leadership for the State Oral Health Program under the direction of a dental professional and staff with public health skills.

NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Inactive - Completed								
Goal:	Develop a state oral health program to improve the health of Hawaii families.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>n/a</td> </tr> <tr> <td>Denominator:</td> <td>n/a</td> </tr> <tr> <td>Unit Type:</td> <td>Text</td> </tr> <tr> <td>Unit Number:</td> <td>Yes/No</td> </tr> </table>	Numerator:	n/a	Denominator:	n/a	Unit Type:	Text	Unit Number:	Yes/No
Numerator:	n/a								
Denominator:	n/a								
Unit Type:	Text								
Unit Number:	Yes/No								
Data Sources and Data Issues:	<p>The Data Collection Form lists 6 strategies:</p> <ol style="list-style-type: none"> 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 <p>The measure will be answer “Yes” when all six steps are completed. No data issues are anticipated.</p>								
Significance:	<p>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.</p> <p>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:</p> <ul style="list-style-type: none"> • 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. <p>Significant barriers have made establishing the positions and hiring challenging.</p>								

ESM 13.2.2 - Completion of teledentistry pilot project at three early childhood settings to reach underserved children.

NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active								
Goal:	Demonstrate the feasibility and effectiveness of teledentistry to improve the oral health of children.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of programs participating</td> </tr> <tr> <td>Denominator:</td> <td>WIC, Head Start, & Tutu & Me pre-school participation</td> </tr> <tr> <td>Unit Type:</td> <td>Text</td> </tr> <tr> <td>Unit Number:</td> <td>Yes/No</td> </tr> </table>	Numerator:	Number of programs participating	Denominator:	WIC, Head Start, & Tutu & Me pre-school participation	Unit Type:	Text	Unit Number:	Yes/No
Numerator:	Number of programs participating								
Denominator:	WIC, Head Start, & Tutu & Me pre-school participation								
Unit Type:	Text								
Unit Number:	Yes/No								
Data Sources and Data Issues:	<p>The process to complete year one of the 3-year project involves several key steps:</p> <ol style="list-style-type: none"> 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 <p>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.</p>								
Significance:	<p>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.</p> <p>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</p>								

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](#)