Maternal and Child Health Services Title V Block Grant

Hawaii

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I. General Requirements

I.A. Letter of Transmittal

DAVID Y. IGE
GOVERNOR OF HAWAII

VIRGINIA PRESSLER, M.D.
DIRECTOR OF HEALTH

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

In reply, please refer to:
File:

July 15, 2015

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

Dear Dr. Lu:

The State of Hawaii wishes to formally apply to the Maternal and Child Health Bureau for continued funding under the Maternal and Child Health Services, Title V Block Grant Program for fiscal year (FY) 2016 (October 1, 2015 – September 30, 2016). The FY 2016 application and FY 2014 annual report is submitted via the Health Resources and Services Administration Electronic Handbooks (EHBs).

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

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

Sincerely,

Virginia Pressler

Virginia Pressler, M.D.
Director of Health

I.B. Face Sheet

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

I.C. Assurances and Certifications

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

I.D. Table of Contents

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

I.E. Application/Annual Report Executive Summary

BACKGROUND

State of Hawaii, Department of Health (DOH)/Family Health Services Division (FHSD) receives approximately $2.2 million in Title V funding from the federal government. Title V of the Social Security Act is the Maternal and Child Health (MCH) Services Block Grant and is a federal program devoted to improving the health of all women, children, and families.

State Title V MCH programs develop, deliver, and support comprehensive public health systems and services in every state and territory for women and children, including children with special health care needs. This work is accomplished by providing health services, linking families to appropriate care, and assuring the capacity of states to address priority health issues.

NEEDS ASSESSMENT

Every five years, FHSD is required by Title V to conduct a statewide needs assessment. The goal of the assessment is to examine data to determine the selection of priorities that will drive state public health work for the next five years. The overall aim is to make a measurable improvement in the health of the MCH populations.

Since the last 5-year needs assessment, FHSD has suffered a significant loss of staffing (20% reduction) and funding, with the elimination of programs and reductions in program eligibility and benefits. This contraction of organizational capacity has occurred at a time of increasing demand for services resulting in a general sense of "overwhelm" among staff. Thus, FHSD conducted the needs assessment cognizant of strategically leveraging existing resources; building upon established collaborative initiatives; capitalizing on partnerships; and developing capacity by building on current programs, initiatives and strategies. Using this approach FHSD was able to reduce duplication of assessment efforts on a small state population, and assure Title V priorities and plans were well-aligned with key partners in public health and the health care system.

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

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

1. Data reflect a need and opportunity for improvement.
2. FHSD could take a lead or major role for the issue.

3. FHSD has capacity and resources (staffing and funding) to address the issue.
4. An expressed interest or concern raised by the community and an opportunity to align efforts with existing groups.

IDENTIFICATION OF STATE PRIORITY NEEDS

Based on the needs assessment, Hawaii selected 5 ongoing priorities and 3 new priorities that reflect emerging needs. Hawaii Title V priorities are:

- Promote reproductive life planning
- Reduce infant mortality: promote breastfeeding and safe sleep practices *(new)*
- Prevent child abuse and neglect
- Promote early childhood screening and development
- Promote adolescent well-being *(new)*
- Promote transition to adult health care
- Improve oral health
- Improve access to services through telehealth *(new)*

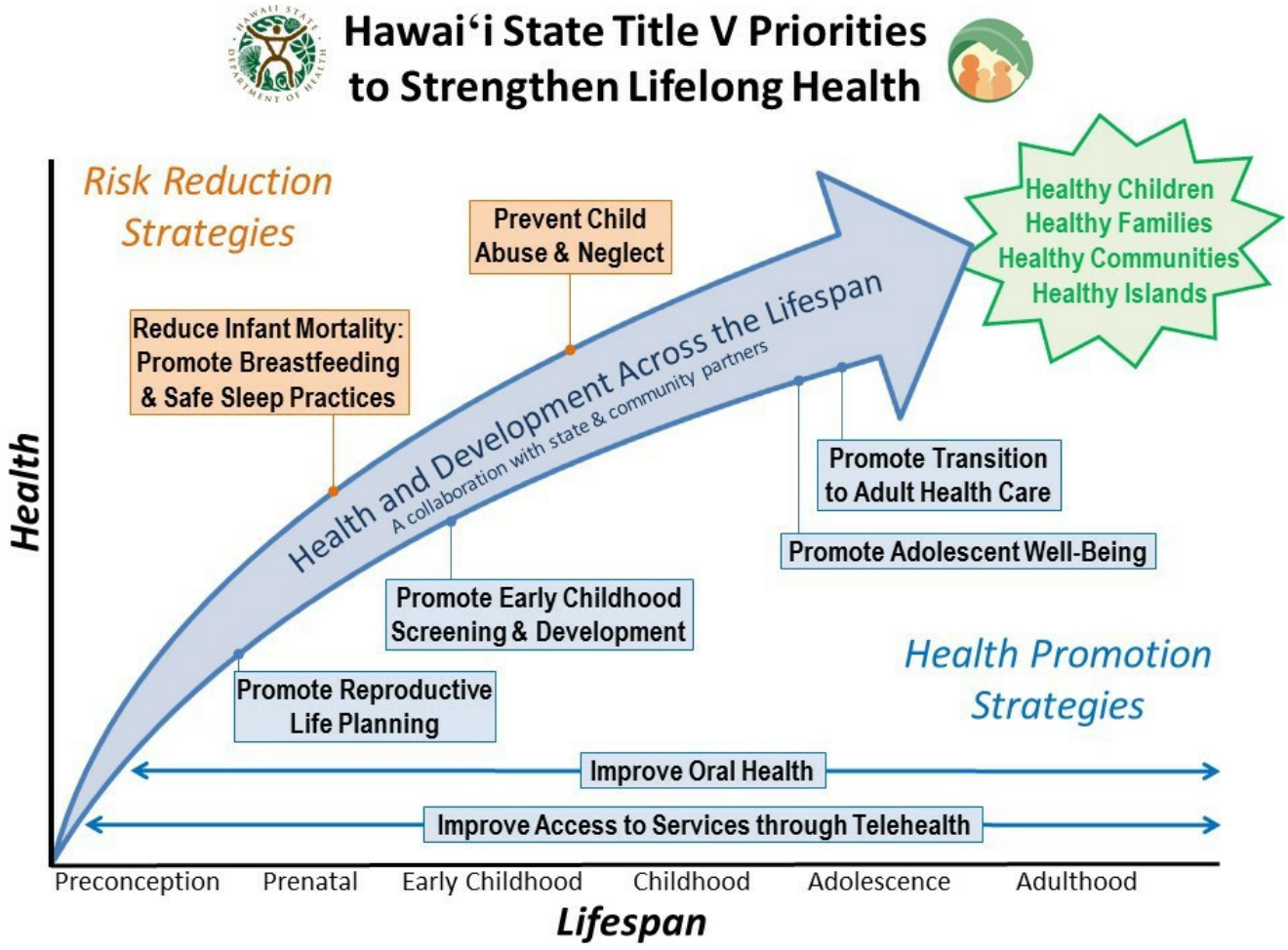


Figure 1. Hawaii Title V priority measures across the lifespan.

ACCOMPLISHMENTS AND PRIORITY NEEDS BY POPULATION DOMAIN

DOMAIN: WOMEN'S/MATERNAL HEALTH

FHSD grants or programs that address perinatal and/or infant health include: Family Planning, Perinatal Support Services, Domestic Violence, Sexual Violence, Hawaii Home Visiting Network, Pregnancy Risk Assessment Monitoring System (PRAMS), Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and Primary Care Contracts. FHSD is part of the Hawaii Maternal and Infant Health Collaborative, a public-private partnership committed to improving birth outcomes and reducing infant mortality (see Perinatal/Infant Health below). This collaborative was developed in partnership with the Executive Office of Early Learning's Action Strategy, with help from the DOH and National Governor's Association, and includes physicians/clinicians, public health planners and providers, insurance providers, and health care administrators.

Priority: Promote reproductive life planning

Related National Performance Measure: Percent of women with a past year preventive medical visit.

Plans include:

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

DOMAIN: PERINATAL/INFANT HEALTH

Grants or programs that address perinatal/infant health include: PRAMS, Fetal Alcohol Spectrum Disorders, Home Visiting Network, Family Planning, Perinatal Support Services, WIC Services, and WIC Breastfeeding. FHSD is part of the Hawaii Maternal and Infant Health Collaborative, a public-private partnership to improve birth outcomes and reduce infant mortality through promoting preconception health care, promoting reproductive life planning, promoting healthy behaviors across the lifespan, improving access and utilization of appropriate prenatal care, promoting appropriate care for mothers at risk, promoting appropriate time and method of delivery, promoting healthy behaviors in at risk populations, and promoting infant well-being.

Priority: Reduce the rate of infant mortality by improving breastfeeding rates and promoting safe sleep practices.

Related National Performance Measures: Percent of infants who are ever breastfed; percent of infants breastfed exclusively through 6 months; percent of infants placed to sleep on their backs.

Plans for breastfeeding include:

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

Plans for promoting safe sleep practices include:

- Review all birthing hospital policies and training needs.
- Increase infant safe sleep environment knowledge for caregivers.
- Safe sleep behavior is understood and championed by trusted individuals.
- Collect information on co-sleeping beliefs and behaviors among diverse cultures in Hawaii.

DOMAIN: CHILD HEALTH

FHSD has many grants and programs that promote child health and wellness, in areas that include immunization, injury prevention, medical home, nutrition, oral health, and screening, in collaboration with many State and community partners. The Early Childhood Comprehensive Systems grant is focusing on developmental screening activities of infants and toddlers in early childhood programs. Programs with a focus on child abuse and neglect prevention

include Community Based Child Abuse Prevention, Hawaii Children's Trust Fund, Parenting Support, and Child Death Review. The Home Visiting Program received grant funding for Maternal, Infant and Early Childhood Home Visiting to strengthen current home visiting services, increase enrollment of prenatal women through partnerships with WIC clinics across the State, and strengthen home visiting effectiveness in prenatal health and birth outcomes, school readiness, and coordination of referrals to community resources.

Priority: Promote Early Childhood Screening and Development – Improve the percentage of children age 0-5 years screened early and continuously for developmental delay.
Related National Performance Measure: Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool.
Plans include:

- Develop infrastructure for on-going training, technical assistance, and support for practitioners conducting developmental screening activities.
- Develop protocols, guidelines and standardized referral processes and communication system on developmental screening.
- Develop data system to track and monitor screening, referral, utilization system
- Develop collateral material needed to support understanding and importance of developmental screening.
- Develop website to house materials, information, and resources on developmental screening.

Priority: Prevent Child Abuse and Neglect – Reduce the rate of child abuse and neglect with special attention on ages 0-5 years.
Related National Performance Measure: Rate of hospitalization for non-fatal injury per 100,000 children age 0 through 9 and adolescents age 10 through 19 years.
Plans include:

- Raise awareness about the importance of safe and nurturing relationships to prevent child abuse/neglect.
- Improve evaluation capacity of Family Support and Violence Prevention Section programs to assure improved outcomes.
- Improve collaboration and integration between programs addressing child wellness and family strengthening.

DOMAIN: ADOLESCENT HEALTH

- MCH Branch, with the Adolescent Program, continues to promote adolescent development, in collaboration with public and private groups, community organizations, and youths. Its work includes teen pregnancy prevention with the support of three federal grants, and serving on the Hawaii School Health Survey Committee which is now preparing for the administration of the 2015 Youth Risk Behavior Survey.

Priority: Promote Adolescent Well-Being – Improve the healthy development, health, safety, and well-being of adolescents.
Related National Performance Measure: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Plans include:

- Promote current "Bright Futures" guidelines for adolescents.
- Incentivize providers, adolescents & parents to encourage preventive care.
- Encourage teen-centered health care.
- Leverage missed opportunities to increase adolescent preventive services.
- Develop partnerships with key community stakeholders.

DOMAIN: CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

Children with Special Health Needs Branch (CSHNB) continues efforts toward improving access for CSHCN and their families to a coordinated system of family-centered health care services and improving outcomes, through systems development, assessment, assurance, education, collaborative partnerships, and family support. CSHNB programs include: Children with Special Health Needs, Early Intervention, Genetics, Newborn Hearing Screening, Newborn Metabolic Screening, and Birth Defects Programs. DOH supported the passage of two legislative bills that became law in July 2015 – Act 212 requires birthing facilities to screen newborns for critical congenital heart defects and report data to DOH, and Act 213 requires insurance coverage of medically necessary orthodontic treatment for orofacial anomalies for individuals under age 26 years. CSHNB staff planned and promoted Transition Fairs on Oahu and Neighbor Islands, in coordination with many state and community partners.

Priority: Promote Transition to Adult Health Care – Improve the percentage of youth with special health care needs ages 14-21 years who receive services necessary to make transitions to adult health care.
Related National Performance Measure: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care.
Plans include:

- Convene agency and community stakeholders to develop strategies to improve services for adolescents and their families necessary to make transition to adult health care.
- Provide education/training on transition to adult health care.
- Develop educational materials to "chunk" manageable steps for transition for younger ages.
- Promote staff development in transition issues via webinars, trainings, etc.

DOMAIN: CROSS-CUTTING OR LIFE COURSE

FHSD grants or programs that address issues across all population health domains include: State System Development Initiative, State Office of Rural Health, Primary Care Office, Critical Access Hospitals (Flex Program), Oral Health, Primary Care Contracts, Rural Hospital Subsidy Contracts, and Genetics Program. The Oral Health Program is continuing with its efforts to promote oral health, through rebuilding the DOH oral health infrastructure including surveillance, planning and prevention functions, in collaboration with many federal, national, state, and community partners and funding resources. Its work has included: funding a dental director position to provide program leadership; developing an Oral Health Data report; conducting a third grade oral health Basic Screening Survey to assess the oral health status of children in 66 public and charter schools on six islands; contracting a policy review of oral health legislation; contracting a program profile of key state oral health programs, services, resources; planning a pilot school-based dental sealant program; and contracting fluoride varnish training with pediatric providers. The Genetics Program currently works to increase access to genetic services on the Neighbor Islands, with in-person clinics and telehealth via videoconferencing for genetic consultations.

Priority: Improve oral health – Improve the oral health of children ages 0-18 years and pregnant women.
Related National Performance Measure: Percent of women who had a dental visit during pregnancy; percent of children, ages 1 through 17, who had a preventive dental visit in the past year.
Plans include:

- 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.

Priority: Improve access to services through telehealth
Plans: To be completed in the FY 2017 application. Plan will include developing a telehealth training and mentoring program to increase workforce knowledge and use of telehealth.

Progress on accomplishments to address the prioritized needs as reflected in the 5-Year Plan will be reported in subsequent annual Title V reports.

FHSD TRANSFORMATION
The revised Title V grant guidance has allowed FHSD to prioritize program efforts in wake of devastating budget cuts, engage important partners to effectively utilize opportunities presented in a changing health care environment, and focus on building workforce capacity to use systems approaches to effectively improve health outcomes.

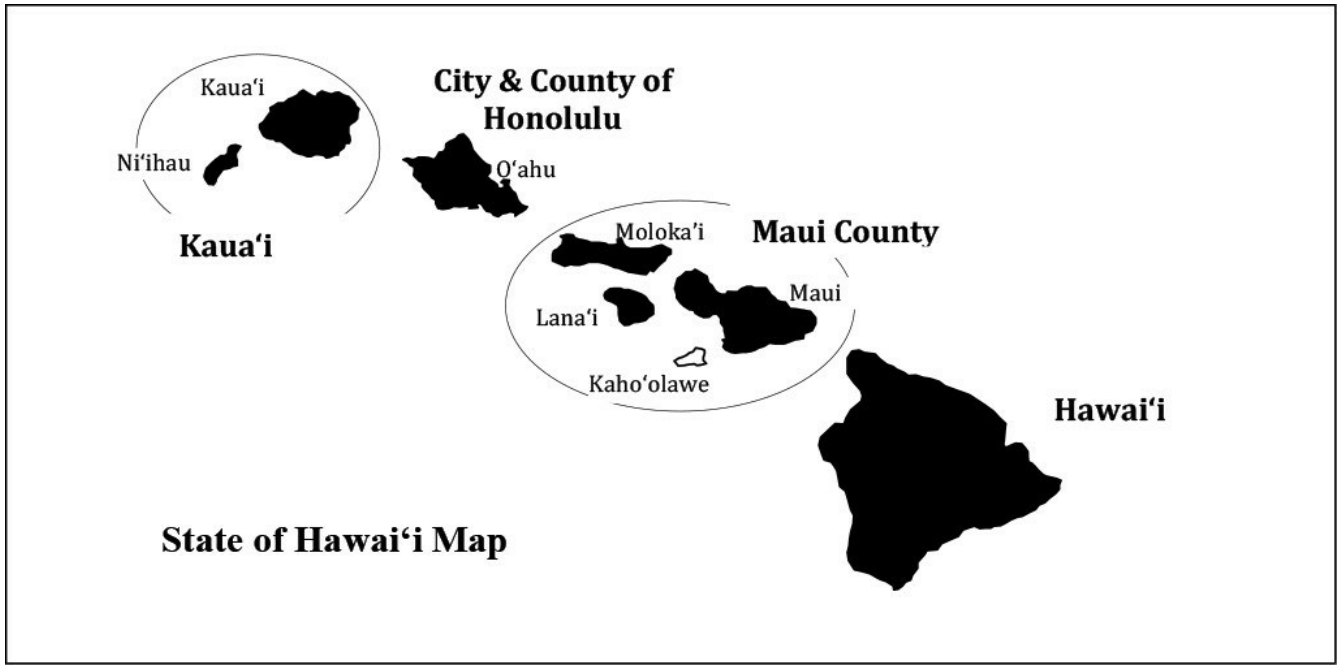
II. Components of the Application/Annual Report

II.A. Overview of the State

GEOGRAPHY

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

The State is composed of 7 populated islands located 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, the latter 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. The majority of tertiary health care facilities, specialty and subspecialty services, healthcare providers are located on Oahu. Consequently, neighbor island and rural Oahu residents often must travel to Honolulu for these services. Interisland passenger travel is entirely by air. Air flights are frequent, but comparatively expensive. Airfare costs can be quite volatile based on

varying fuel costs. This creates a financial barrier for neighbor island residents since round-trip airfare costs range from $130 to over $200.

Geographic access is further limited because public transportation is inadequate in many areas of the state except for the city of Honolulu. 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 primarily on automobiles in order to travel to major population centers where health care services are available including primary care, hospital, specialty, and subspecialty services. Because of the mountainous nature of the islands, road networks have been sparse and, in some places, limited to a single highway near the coast. Access to emergency care on neighbor islands often requires the use of helicopters or fixed-wing aircraft.

DEMOGRAPHICS

According to the 2013 American Community Survey (ACS), estimates the state population has increased slightly, but the distribution of residents has remained largely the same. Oahu continues to be the home of nearly three-fourths (70.0%) of the state's population (983,429 residents), while 13.6% live on the Big Island (190,821 residents), 11.4% (160,202 residents) in Maui County, and 5.0% (69,512 residents) in Kauai County. From 2010 to 2013, the Census Population Annual Estimates Program estimated an overall growth in the state of 3.2%:3.6% on the county of Kauai, 3.5% on the county of Maui, 3.2% on the city and county of Honolulu, and 3.1% on the county of Hawaii.

ETHNIC DIVERSITY

Hawaii is one of the most diverse states in the U.S. comprised of a multitude of racial and ethnic sub-groups across the state. Unlike most of the United States, the ethnic composition of the state's population is very heterogeneous with no single ethnic majority. In 2010 in Hawai'i, 23.6% of the population reported belonging to two or more races, 24.7% were White, 14.5% were Filipino, 13.6% were Japanese and 5.9% were Native Hawaiian. As a group, all Asian groups made up 38.6% of the population, while the composite Native Hawaiian or Other Pacific Islander group made up 10% of the population. Of all residents that reported being Native Hawaiian (289,970), 72.3% reported another race group, which would correspond to account for 21.3% of the state population being Native Hawaiian (alone or in combination with another race group).

Immigration

Hawaii is considered a gateway to the U.S. for immigrants from Asia and the Pacific. According to the 2013 ACS, 17.6% of Hawaii's population is foreign-born, the 6th highest percentage according to the 2013 ACS estimates. Nearly 39,000 immigrants were legally admitted to the state between 2003 and 2013 mainly from the Philippines, Japan, Korea and Vietnam. Smaller groups of Hispanic immigrants have settled in parts of Maui and Hawaii island, attracted by jobs in tourism and agriculture. Estimates of illegal immigrant in Hawaii range from six to nine thousand.

Languages Spoken

Because of this ethnic diversity, limited English proficiency poses challenges for educational achievement, employment and accessing services and may impact the quality of care for immigrant communities. Among Hawaii resident over 5 years of age in 2012, an estimated 25.7% (327,331) spoke a language other than English at home (9th highest state ranking) compared to 20.9% nationally. While 12.7% of Hawaii residents reported limited English proficiency (5th highest state ranking), compared to 8.5% nationally. The most common languages spoken at home other than English include Other Pacific Island languages (111,515), Tagalog (58,197), Japanese (45,621), Chinese (32,054), and Spanish (26,779) followed by Korean (18,079) and Vietnamese (8,201). ACS 2011-2013 estimates.

In 2012, 13.5% (24,750) of the state's public elementary school children were enrolled in the Students with English Language Learners Program. The top five languages spoken by Hawaii public school students are Ikokano, Chuukese, Marshallese, Tagalog, and Spanish.

Compact of Free Association (COFA)

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

There have been reports of high rates of morbidity due to chronic disease (Diabetes, Obesity, Smoking), reports of communicable diseases (TB, Hansen's Disease/Leprosy), and other medical concerns (which may be related to U.S. nuclear tests conducted in the Pacific nations) with additional challenges due to substantial language and cultural barriers within the COFA population. In 2014 the social, health, educational, and welfare system costs attributed to the estimated 14,700 COFA migrants in Hawaii was $163 million dollars. Estimates indicate roughly 1,000 migrants are homeless 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.

Military

Other sub-populations within the state include U.S. Armed Forces personnel and their dependents which comprise an estimated 7.8% of the state population (109,458 people). There are several major military health facilities to serve this population located on Oahu. The Triple 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 base through several clinics for active duty members and their dependents.

Homelessness

Hawaii's 2015 Point in Time homeless study conducted in January 2015 estimates the total number of homeless individuals statewide is 7,620. Roughly equal proportions are sheltered (50%) and unsheltered (50%). The trend of homeless has steadily grown over the past 5 years from 6,188 in 2011. About 43.4% (3,313) of the homeless were part of families; with 24.8% (1896) under age 18 years of which 439 were unsheltered. Children in particular are affected by homelessness which has been linked to behavioral health problems and negatively impacts educational progress.

Age Distribution

Hawaii's population, like the U.S. as a whole is aging. The median age of Hawaii residents increased from 36.2 to 38.6 over the last decade, higher than the national average of 37.2 in 2010. The largest increase since the 2000 Census was among those 60-64 years of age, representing a 58% increase since 2000, followed by a 57% increase among those 85 years and older, and 38% increase among those 55-59 years of age.

Maternal and Child Population

Based on 2010 Census data, the state population of Hawaii has increased about 12% to 1,360,301 residents compared to 2000 when the population was 1,211,537 with the overall median age increasing from 36.2 years in 2000 to 38.6 years in 2010. In 2010, there were 262,107 women of reproductive age (defined as women 15-44 years old) which represents a small 3% increase from the 2000 census data of 253,854. This group represents about 20% of the entire state population. During the last 24 years, the number of births in Hawaii has varied from about 17,000 to 20,500 annually. There has been a steady increase in the number of births since the late 1990's with about 19,000 births every year in the state over the past 5 years. In 2010, there were 170,768 children 9

years of age or younger in Hawaii which represents a 5% increase from 2000 when there were 163,143. This group represents nearly 13% of the state population. The number of children ages 10-19 years in 2010 (167,533) has increased by 2% since 2000 when there were 164,108 children. This group represents about 12% of the state population. Based on the 2009/10 National Survey of Children with Special Health Care Needs (CSHCN), there are an estimated 35,000 CSHCN, representing 12.3% of all children ages 0-17 years old.

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 is slowly improving since the 2009 recession. Initially bolstered by strong Asian markets, Hawaii is doing relatively better than the U.S. overall. In a number of economic sectors; however, including tourism, the period of swift growth is waning. Growth is expected to continue, but will be more measured, according to state economic researchers.

Economic Growth

Hawaii's economy is forecast to continue its slow, steady expansion in 2015, although tourism's contribution to growth appears to be weakening according to the State Department of Business, Economic Development and Tourism (DBEDT). The state real gross domestic product (GDP) estimate for 2014 is 2.4% due to lower-than-expected growth in tourism and personal income. The per capita real GDP in Hawaii was $49,934 in 2013 (in 2009 dollars), $819 or 1.7% 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 recession with a record 47,000 individuals unemployed. According to the Bureau of Labor Statistics (BLS), the seasonally adjusted unemployment rate for Hawaii was 4.4% in 2014. The state unemployment rate was 1.9 percentage points lower than the national rate for the month (6.3%). The Hawaii unemployment rate during the first quarter of 2014 was the 6th lowest in the nation.

State Budget

Because tax revenues grew much faster in 2015, the State Council on Revenues in May 2015 increased its forecast for growth of the State General Fund tax revenues for FY 2015 from 5.5% to 7.5%. However, the Council noted the increase was largely due to delays in issuance of state tax refunds, a result of new fraud prevention procedures adopted by the State Tax Office. Optimistic about the future, the Council maintained its forecasts for FY 2016 (7.5% increase) and FY 2016 (2.7% increase).

Tourism

Overall, 2014 was another record breaking year for tourism with nearly 8.24 M travelers coming to the islands and visitor expenditures topping $14.5 B. Always vulnerable to changing markets and trends, forecasters believe tourism numbers will decline in 2015 due to unfavorable exchange rates, the increased the cost of a Hawaii stay, and the slow U.S. economy.

Poverty

Hawaii's poverty rate in 2012 was 11.8% (all ages in poverty). This represents an estimated 159,988 individuals living in poverty in the state; over 51,557 or 17.2% of those under 18 years of age live in households below the federal poverty level. Like unemployment rates, poverty rates are variable across counties: Honolulu 10.4%; Maui, 11.2%; Kauai 12.3%; and Hawaii 18.9%.

The official poverty rate ranks Hawaii as the 18th lowest in the nation. However, the official federal poverty level

obscures the struggles faced by many families in Hawaii because of the high cost of living in the state and the generally low wage structure given the dependence of service industry jobs in tourism. The Census supplemental poverty rate (which considers factors such as the cost of living, entitlements) for 2011-2013 for Hawaii was 18.4%, 5th highest in the U.S.

Wages

According to the Bureau of Labor Statistics, average annual wages for employees in Hawaii was $43,845 in 2013, $5,963 or 12% lower than the U.S. average. Hawaii ranked 29th among the 50 states. Among private sector employees only, the situation is worse. Average annual wages for employees in the private sector was $41,485 in 2013, $8,216 or 16.5% lower than the U.S. average; ranking Hawaii 37th.

HIGH COST OF LIVING

Hawaii has the highest cost of living in the nation - nearly 65 percent higher national average. In a recent report by money.com, “The Best and Worst States to Make a Living 2015,” ranked Hawaii as the worst state to make a living. When adjusted for taxes and the cost of living, the study found the buying power for average Hawaii wage earners was 55 cents to the dollar compared to the national average.

Housing Costs

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

Cost of Home Ownership

In 2012, the median housing cost for a single family dwelling was $647,000and $340,000 for a condominium (Honolulu Board of Realtors). The median monthly owner mortgage costs in 2011-2013 was $2,267, $783 or 52.8% higher than the U.S. average. Among these homeowners, 36.7% spent *35% or more of their household income*, 10.7% higher than the U.S. average. Hawaii ranked the highest in the nation for this indicator. Not surprisingly, the homeownership rate in Hawaii was one of the lowest in the U.S. (48th among the 50 states) at 57.7% in 2010, 7.4% point lower than the U.S. average of 65.1%.

Rental Costs

Even for working families, the high cost of fair market rent is out of reach. Hawaii was listed for the fifth straight year as having the least affordable rental costs in the Nation. In 2012 estimated 43.1% of Hawaii residents rent (compared to 20.7% nationally). The median monthly gross rent for the renter-occupied units (excluding units not paying rent) in Hawaii during the 2011-2013 period was $1,387 in 2013 dollars, $487 or 54.1% higher than the U.S. average.

Multi-generational Households

Another consequence of high housing costs is the high number of multigenerational household. Hawaii had the highest rate of multigenerational household (11.6% during the 2011-2013 period), 5.9% point higher than the U.S. average of 5.7%.

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 State Insurance Commissioner, the average health insurance group plan premium

rate increase significantly declined from 2011 to 2014 to a 4% annual average increase compared to 9.3% annual increases between 2007 and 2010. The impact of the Affordable Care Act on individuals and family budgets/expenses has yet to be determined.

HEALTH INSURANCE & HEALTHCARE REFORM

Hawaii has supported the Affordable Care Act (ACA) as a means to attain universal health care coverage for Hawaii's relatively small uninsured population (7.2% in 2012 compared to 15.7% nationally). Hawaii's employer-based health care mandate, the Hawaii Prepaid Healthcare Act, has historically assured a large proportion of the residents with health care insurance for nearly 40 years. Thus, the focus on enrollment is not as significant for Hawaii as it is for other states.

The major health coverage provision of the ACA went into effect in January 2014 providing new options for people who did not have insurance and sweeping new protections for those who buy health plans on their own. Hawaii was one of the first states to pass legislation to create a health benefit exchange call the Hawaii Health Connector. Hawaii also elected to accept the Medicaid expansion provision of the ACA that increases coverage to 138% of federal poverty level. This allows more low-income individuals and families to qualify for Medicaid with no cost to the state since the federal government is expected to cover the cost of Medicaid expansion at 100%.

ACA also affords consumer protections including ten Essential Health Benefits. Several provisions of ACA strengthen coordination and integration of services among health care providers by establishing Accountable Care Organizations (ACO), adoption of Patient-Centered Medical Home (PCMH) model of care. As a result, Hawaii Medical Services Association (HMSA), Hawaii's largest insurance provider, which covers 70% of the lives in Hawai'i through Medicaid, Commercial, health maintenance organization (HMO), and Medicare Advantage plans, has the largest community-based programs for both PCMH and ACO in the state. All of the Medicaid plans have PCMH requirements in their contract with DHS.

Unfortunately, much of the ACA attention has focused on the failed state health exchange, the Hawaii Health Connector. In May 2015 the Governor announced Hawaii would comply with federal requests to transition the Connector to the federal healthcare.gov platform by October because Hawaii was not able to become financially self-sustaining by the January 2015 deadline— a requirement for all state-based exchanges under the ACA. Nor was Hawaii able to integrate Medicaid enrollment into the Connector, another federal requirement for state exchanges.

Current Connector enrollees will be able to retain their coverage for 2015, but will have to re-enroll through Healthcare.gov for 2016 coverage. Open enrollment for 2015 has ended, although people who experience a qualifying life event can sign up for coverage within 60 days of the event, and Medicaid enrollment is open year-round. Since the Connector was launched in the fall of 2013, more than 30,000 people have enrolled in private insurance and about 60,000 people have enrolled in Medicaid through Hawaii's marketplace.

In March 2015, 7,617 adult COFA individuals on Medicaid were transferred to the Connector health insurance plans. 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. These changes reduced the cost of medical assistance to COFA individuals from $58.3 million to a projected $29.1 million. With this coverage COFA adult migrants must pay costs as co-payments, deductibles and premiums. However, the state Medicaid Premium Assistance Program helps, by paying the premiums for eligible COFA migrants and legally permanent residents who have incomes less than 100 percent of the federal poverty level.

MEDICAID

In 1993, Hawaii secured approval for one of the first section 1115 demonstration projects designed to use a managed care delivery system to create efficiency in the Medicaid program and enable the extension of coverage to individuals who would otherwise be without health insurance. The program is administered by the Department of Human Services 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.

In 1996, economic changes led to a tightening of QUEST eligibility. The income requirement was changed from 200 percent of the Federal Poverty Level (FPL) to 100 percent, and enrollment was capped at 125,000 members, down from the high of 160,000. Certain groups are not subject to the cap and can enroll at any time: pregnant women, children under 19 years of age, foster children and children in subsidized adoptions under age 21, adults whose incomes do not exceed the TANF payment limit, and people who apply within 45 days of losing their employer sponsored coverage due to loss of employment. Full Medicaid benefits are provided to former foster children under age 26 with income up to 300% of federal poverty level with no asset limit.

Through an additional waiver in 2006 DHS also expanded services by covering more low-income adults, by establishing the QUEST-ACE (Adult Coverage Expansion). QUEST-ACE offers a limited-benefit package that provided for inpatient and outpatient care, emergency room visits, mental health services, diagnostic tests, immunizations, alcohol and substance abuse treatments, and limited prescription drug coverage. Men and women over the age of 19 without dependent children are eligible whose annual earnings are at or below 133% of the FPL. The program is designed to help adults who could not previously qualify for QUEST due to the 1996 enrollment cap. The waiver also allowed the state to continue to make direct payments to hospitals to offset the costs of caring for the uninsured.

In 2009, Hawaii expanded it‘s provision of managed care services to include individuals with disabilities and those over 65 through QUEST Expanded Access (QExA). Two specialized health plans were selected. Besides state plan services, QExA included Medicaid long term services and supports, and service coordination within a managed care framework. Individuals under 65 and without disabilities were still served through QUEST.

DHS renewed its 1115 Demonstration waiver with Centers for Medicare & Medicaid Services (CMS) that went into effect on October 1, 2013. The renewed waiver is called QUEST Integration (QI). This 1115 Demonstration waiver allowed the State of Hawaii to implement provisions under the Affordable Care Act (ACA). Hawaii converted its eligibility standards to a Modified Adjusted Gross Income (MAGI) methodology to comply with ACA.

In addition to the expanded eligibility, QI, required health plans to provide services to all populations, with and without disabilities, over and under 65. This is one of the most signifant hallmarks of the new program. 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 QI beneficiaries statewide, except for Kaiser Foundation Health Plan, which has chosen to operate only on the islands of Oahu and Maui. As of April 2015 total Medicaid enrollment was 336,680, an increase from 2013. Due to the state economic downturn and implementation of ACA, Medicaid programs observed an approximately 96% increase in enrollments since 2008.

Dental coverage is a comprehensive benefit for children but limited to emergency and palliative services for adults and was moved from managed care to fee-for-service in October 2001. In 2014, the State Legislature appropriated

$1.5M to expand dental coverage for adults. DHS had requested approximately $4 M per year to implement adult dental. DHS will not be able to meet all adult dental needs with appropriated funds.

Children's Health Insurance Program Reauthorization Act

Hawaii's SCHIP program, a Medicaid expansion, began on July 1, 2000, and covers all children under 19 years of age with family incomes up to 300% of the Federal Poverty Level (FPL) for Hawaii. There is no waiting period for SCHIP eligibility. All immigrant children and pregnant women who are Legal Permanent Residents or citizens of a Compact of Free Association nation are enrolled in a Medicaid program under CHIPRA. As of April 2015, 25,601 children were enrolled in CHIPRA.

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 Department of Human Services (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 the 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. DOH works with the Governor-appointed Board of Health to set state public health policies. 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, WIC, and Children with Special Health Needs Branches.

Hawaii elected a new Governor in November 2014. Democratic Governor David Ige has been a state legislator for more than 35 years, most recently chairing the state senate budget committee. Along with Lt. Governor Shan Tsutui, the new Governor assumed office December 2014. Management and priorities are shifting with the replacement of all government department directors with new political appointments.

At DOH the former Title V director and Family Health Services Division Chief, Danette Wong-Tomiyasu was appointed to serve as the new DOH Deputy for Health Resources Administration. The position is under recruitment, but has been vacant since January 2015.

STATE DEPARTMENT OF HEALTH: CURRENT PRIORITIES & INITIATIVES

New priorities and initiatives for the State Health Department have yet to be announced.

II.B. Five Year Needs Assessment Summary

II.B.1. Process

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

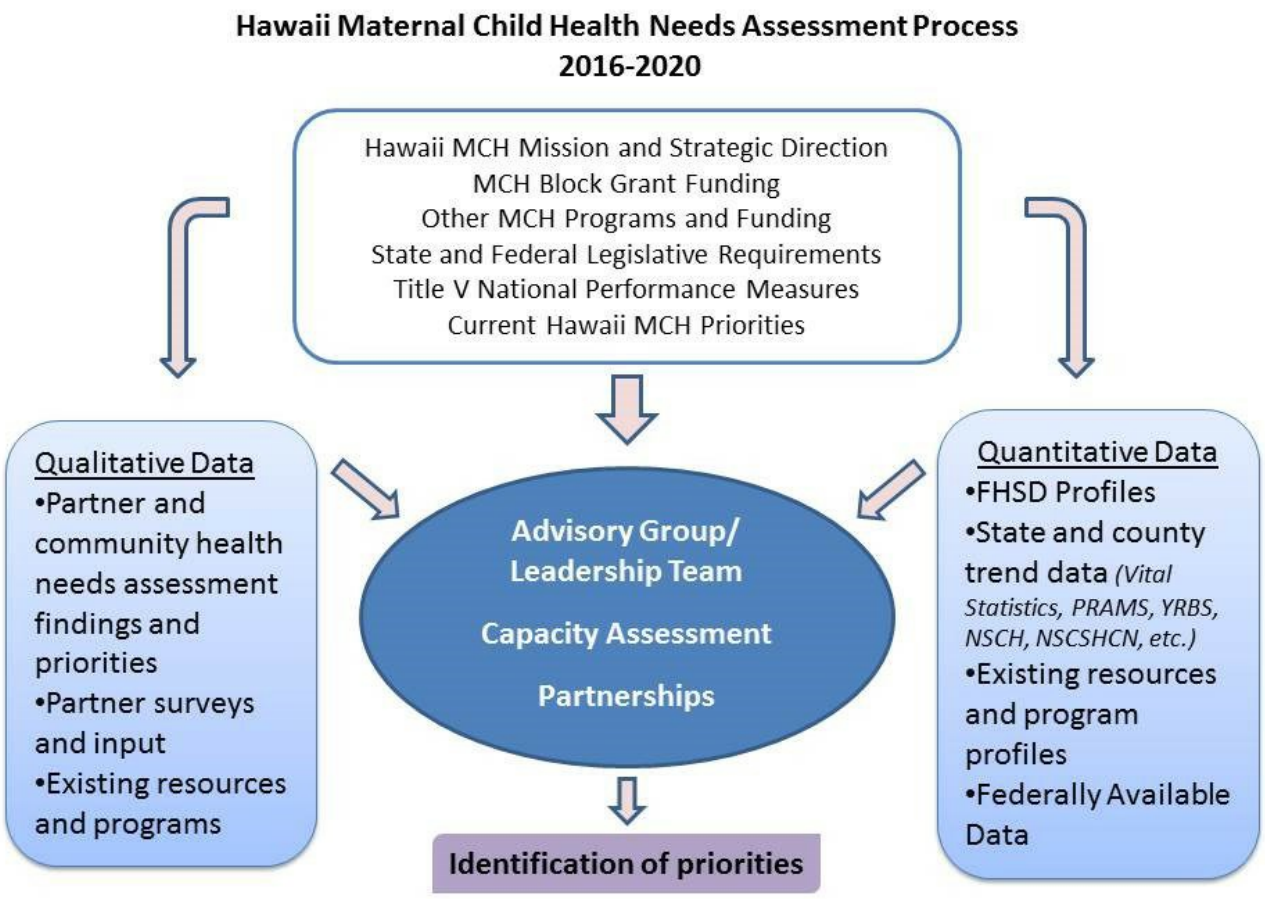
GOALS, FRAMEWORK, AND METHODOLOGY

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

The needs assessment framework included:

- Life course approach: Experiences or exposures during critical periods of an individual's life (e.g., infancy, childhood, adolescence, and childbearing age) can have long-term implications.
- Social determinants of health and health equity:Broad social, economic, and environmental factors must be addressed to promote health and achieving health equity.
- System of health care is family/patient-centered, community-based, and prevention-focused, with early detection and treatment/intervention for those with chronic conditions.

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



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

STAKEHOLDER INVOLVEMENT

Stakeholder input was obtained in several ways:

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

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

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

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

QUANTITATIVE AND QUALITATIVE METHODS

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

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

DATA SOURCES

Sources of quantitative data included:

- **FHSD Profiles 2014**, which includes data from some sources below.

- **Federally Available Data** (FAD), in the FAD Resource Document and Title V Information System, includes sources below.

- **Behavioral Risk Factor Surveillance System Survey** (BRFSS)

- **National Immunization Survey** (NIS)

- **National Survey of Children's Health** (NSCH)

- **National Survey of Children with Special Health Care Needs** (NSCSHCN)

- **National Vital Statistics System** (NVSS)

- **Office of Health Status Monitoring** (OHSM) – DOH vital statistics

- **Pregnancy Risk Assessment Monitoring System** (PRAMS)

- **State Inpatient Databases** (SID)

- **Youth Risk Behavior Surveillance System** (YRBS)

Sources of qualitative data included:

- **American Academy of Pediatrics (AAP)-Hawaii Chapter, Position Paper:Pediatric Priorities 2015 and Beyond**. A Family Leader participated in its development.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Needs Assessment with review of MCH issues.

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

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

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

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

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

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

II.B.2. Findings

II.B.2.a. MCH Population Needs

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

WOMEN/MATERNAL HEALTH

<u>Reproductive Life Planning/Unintended Pregnancies</u>

Unintended pregnancy is associated with late or inadequate prenatal care, low birth weight, neonatal death, domestic violence, child abuse, and exposure of the fetus to harmful substances such as tobacco, alcohol and other drugs.

Data: Hawaii data show a higher rate of unintended pregnancies (52.0% in2012) compared to the national rate (40.0% in 2011). Hawaii data from 2009-2011 show higher estimates of an unintended pregnancy among live births in women under age 20 years (83.4%) and age 20-24 years (62.4%). (Data source: FHSD Profiles/Hawaii PRAMS, CDC/PRAMS)

FHSD Role: Women's and Reproductive Health Section/Family Planning Program (FPP) is the FHSD lead for this area. FPP assures access to affordable birth control and reproductive health services to all individuals of reproductive age.

FHSD Resources: FPP, Perinatal Support Services, Home Visiting Network, and WIC Branch include services that support women during the interconception period, including reducing future unintended pregnancies. FHSD

participants on the Hawaii MIH Collaborative include Women's and Reproductive Health Section, WIC Branch, and MCH Epidemiologist.
Community Alignment: State of Hawaii Community Health Needs Assessment identified family planning as one of the 10 highest ranked indicators reflecting local priorities. It noted that family planning is a need for particular groups, primarily low-income families. Hawaii MIH Collaborative's strategic plan includes promoting reproductive life planning. Healthy Mothers Healthy Babies Coalition of Hawaii/Perinatal Advocacy Network includes a focus to improve use of contraception to prevent unintended pregnancy. State Health Improvement Plan (draft) includes reproductive life planning.
Hawaii Title V priority issue? – Met all criteria.

Preventive Health Visits: Preventive health visits help women to adopt or maintain healthy habits and behaviors, detect early and treat health conditions, plan for a healthy pregnancy, and consider reproductive life planning.
Data: For women with a past year preventive medical visit, the Hawaii rate (62.3%) is lower than the national rate (65.2%). Lower Hawaii rates are associated with household income/poverty <$15,000 (53.2%) and unmarried status (55.8%). (Data source: FAD/BRFSS 2013)
FHSD Role: Women's and Reproductive Health Section will be responsible for this area.
FHSD Resources: Same as for Unintended Pregnancies above.
Community Alignment: Hawaii MIH Collaborative's strategic plan includes promoting preconception health care. State Health Improvement Plan (draft) includes promoting preconception care, reproductive life planning, and healthy behaviors for women during the pre- and inter-conception period.
Hawaii Title V priority issue? – Met all criteria.

Low Risk Cesarean Deliveries
For low-risk pregnancies, cesarean delivery may pose avoidable maternal risks of morbidity and mortality, including hemorrhage, infection, and blood clots.
Data: For cesarean deliveries among low-risk women, the Hawaii rate (19.1%) is less than the national rate (26.8%). (Data source: FAD/NVSS 2013)
FHSD Role: FHSD does not have a lead role, but contributes as part of the Hawaii MIH Collaborative.
FHSD Resources: Limited. FHSD staff participate as part of the Hawaii MIH Collaborative.
Community Alignment: Hawaii MIH Collaborative's strategic plan includes promoting appropriate timing and method of delivery, including reducing early elective deliveries and decreasing primary cesarean deliveries. State Health Improvement Plan (draft) includes reducing elective deliveries and decreasing primary cesarean sections.
Hawaii Title V priority issue? – Did not meet criteria for FHSD role or resources.

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

PERINATAL/INFANT HEALTH
Infant Mortality
Infant deaths reflect the overall state of maternal and infant health. Risk factors include low birth weight, short gestation, race/ethnicity, access to medical care, sleep positioning, and exposure to smoking.
Data: The infant mortality rate (deaths per 1,000 live births) for Hawaii was 6.1 in 2013, which was slightly below the national rate of 6.4 in 2009. This was an increase from the previous two years, when Hawaii experienced the lowest infant mortality rates ever documented in the state (4.9 in 2011 and 4.7 in 2012). Infant mortality rates for 2011-2013 were higher for maternal age younger than 20 years (11.2), and infants who were black (11.1) or Samoan (10.1). (Data source: FHSD Profiles/OHSM)
FHSD Role: FHSD has a strong role, with responsibility shared among various programs/staff participating as part

of the Hawaii MIH Collaborative.
FHSD Resources: Women's and Reproductive Health Section, WIC Branch, and MCH Epidemiologist are active participants of the Hawaii Maternal and Infant Collaborative.
Community Alignment: Hawaii MIH Collaborative's strategic plan includes promoting preconception health care, promoting reproductive life planning, promoting healthy behaviors across the life span, improving access and utilization of appropriate prenatal care, promoting appropriate care for mothers at risk, promoting appropriate timing and method of delivery, promoting healthy behaviors in at-risk populations, and promoting infant well-being.
Hawaii Title V priority issue? – Met all criteria.

BREASTFEEDING: Breastfeeding has been shown to lower the risk of Sudden Infant Death Syndrome. Health advantages of breastfeeding include nutritional, immunological and psychological benefits to both mother and infant as well as economic benefits.
Data: For infants who are ever breastfed, the Hawaii rate (89.5%) is higher than the national rate (79.2%). Lower rates are associated with education/high school graduate (82.4%), and household poverty 100-199% (81.0%). For infants who are breastfed exclusively through 6 months, the Hawaii rate (26.4%) is higher than the national rate (18.8%). Lower rates are associated with household income-poverty ratio <100% (21.0%), unmarried status (20.7%), race/ethnicity Hispanic (17.0%) and non-Hispanic multiple race (19.9%), and rural residence (19.6%). (Data source FAD/NIS 2011)
FHSD Role: WIC Branch is the lead for this area and is currently working on this issue.
FHSD Resources: WIC encourages breastfeeding, through information, counseling, incentives, ongoing support including breast pumps, and training WIC breastfeeding peer counselors. FHSD collaborates with Healthy Hawaii Initiative on the Baby-Friendly Hospital Initiative to encourage policies/practices to support exclusive breastfeeding in maternity facilities. Perinatal Support Services contracts with providers ensure comprehensive breastfeeding education and support to high-risk pregnant women at sites in Honolulu, Maui, Molokai and Kauai. Women's and Reproductive Health Section contracts Healthy Mothers Healthy Babies Coalition of Hawaii to administer a statewide information/referral phone line and website for pregnant women and their infants that includes information on breastfeeding and lactation support services. Hawaii Home Visiting Network promotes breastfeeding through health education and information during and after pregnancy.
Community Alignment: Hawaii MIH Collaborative's strategic plan includes promoting healthy behaviors in at-risk populations, including increasing breastfeeding exclusivity. Healthy Mothers Healthy Babies Coalition of Hawaii/Perinatal Advocacy Network includes a focus to increase breastfeeding. Hawaii Physical Activity and Nutrition Plan 2013-2020 includes an objective to increase exclusive breastfeeding through six months by adopting policies and practices that support breastfeeding. State Health Improvement Plan (draft) includes breastfeeding.
Hawaii Title V priority issue? – Met all criteria.

SAFE SLEEP: Sleep-related deaths are the leading cause of infant death after the first month of life. Recommendations to reduce the risk include back (supine) sleep position, safe sleep environment, breastfeeding, and avoiding smoke exposure during pregnancy and after birth.
Data: For infants placed to sleep on the back on their backs, the Hawaii rate (78.1%) is higher than the national rate (74.2%). Lower rates are associated with education/high school graduate (71.4%), Medicaid insurance (70.6%), and maternal age 20-24 years (71.8%). (Data source: FAD/PRAMS 2011)
FHSD Role: Parenting Support Program is the lead for this area and currently works on this issue.
FHSD Resources: Child Death Review Program reviews data on infant sleep-related deaths to identify areas in need of intervention. Parenting Support Program contracted the publishing of "Safe Sleep for all Hawaii's keiki" flyer which is distributed to families of newborns in Hawaii. Hawaii Home Visiting Network for at-risk families with children 0-5 years old promotes education on safe sleep. WIC routinely screens participants for tobacco use and secondhand smoke within the home, informs participants of dangers of tobacco use in the household, and provides

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

Perinatal Regionalization

American Academy of Pediatrics recommends that very low birthweight infants be born in only Level III or IV Neonatal Intensive Care Units (NICUs) to improve outcomes.
Data: Federally Available Data are not available.
FHSD Role: FHSD does not have a lead role, but contributes as part of the Hawaii MIH Collaborative.
FHSD Resources: Limited.
Community Alignment: Three Level III NICUs on Oahu serve the State of Hawaii – Kapiolani Medical Center for Women and Children (KMCWC), Tripler Army Medical Center, and Kaiser Permanente Medical Center Moanalua. KMCWC services include air transport of neonates from Neighbor Island hospitals to Oahu NICUs. Hawaii MIH Collaborative's strategic plan includes improving access and utilization of appropriate prenatal care, including perinatal regionalization.
Hawaii Title V priority issue? – Did not meet criteria for data, FHSD role or resources.

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

CHILD HEALTH

Developmental Screening

Screening is important for the early identification of developmental concerns and appropriate follow-up, including monitoring or referrals to early intervention or special education services.
Data: For children age 10-71 months receiving a developmental screening using a parent-completed screening tool, the Hawaii rate (38.9%) is higher than the national rate (30.8%). The Hawaii rate is lower than five other states (range 40.8 to 58.0%). (Data source: FAD/NSCH 2011/12)
FHSD Role: Early Childhood Comprehensive Systems (ECCS) Coordinator is the FHSD lead for this area and the co-lead for the Early Childhood Action Strategy/On-track Health and Development.
FHSD Resources: ECCS grant utilizes a public-private partnership model to build comprehensive developmental screening activities in Hawaii. Developmental screening is provided by the Hawaii Home Visiting Network. FHSD contracts for community health centers encourage developmental screening as part of well-child visits. Children with developmental concerns may be referred for DOH Early Intervention services for children age 0-3 years, as mandated by Part C of Individuals with Disabilities Education Act.
Community Alignment: AAP-Hawaii Chapter priorities for 2015 and beyond include developmental screening and psychosocial/behavioral assessment, using validated screening tools, beginning at infancy through the early elementary school years. Early Childhood Action Strategy/On-track Health and Development includes objectives to coordinate with partners a package of comprehensive screenings for early detection; create a framework for a screening-referral-utilization of services feedback loop within the medical home model; and establish an early childhood tracking system to monitor health and development. Hui Kupaa's Early Childhood Workgroup is focusing on early childhood screening (development, vision, and hearing) in two communities on Oahu. Hawaii State Council on Developmental Disabilities 2012-2016 State Plan includes an objective to partner with pediatric providers and agencies to assure access to developmental screenings.
Hawaii Title V priority issue? – Met all criteria.

Child Abuse and Neglect Prevention

Child maltreatment results in immediate physical or emotional harm or threat of harm to a child.
Long-term, victims of abuse are more likely to experience problems such as drug abuse, delinquency, teen pregnancy, mental health problems and abusive behavior.
Data: The Hawaii rate of confirmed cases of child abuse and neglect per 1000 children age 0-5 years is 6.2 in 2014, unchanged from 2013. No national comparative data is available. (Data source: University of Hawaii Manoa/Center on the Family, Department of Human Services, US Census Bureau)
FHSD Role: Family Support and Violence Prevention Section is the lead for this area and is currently working on this issue.
FHSD Resources: Maternal Infant Early Childhood Home Visiting grant provides funding for the Hawaii Home Visiting Network for at-risk families with children age 0-5 years. MCH Branch is the public sector partner for the Hawaii Children's Trust Fund, which is a public/private partnership to support family strengthening programs aimed at preventing child abuse and neglect. MCH Branch administers a federal Community-Based Child Abuse Prevention grant to support community-based efforts to prevent child abuse and neglect. Parenting Support Program contracts a Parent Line to provide informal counseling and referrals and address questions about child development and behavior, family issues, and community resources through various publications.
Community Alignment: Early Childhood Action Strategy includes Nurturing and Safe Families, which has objectives to identify family strengthening supports and services, develop family strengthening core competencies and trainings for early childhood practitioners, and advance family strengthening public awareness and community engagement. Child Care and Development Block Grant, administered by Department of Human Services, has health and safety requirements (including prevention of shaken baby syndrome and abusive head trauma) for child care providers. State Health Improvement Plan (draft) includes Child Abuse and Neglect Prevention.
Hawaii Title V priority issue? – Met all criteria.

INJURIES: Injuries are the leading cause of death among children. Non-fatal injuries due to child abuse and neglect may result in hospitalization.
Data: For children ages 0-9 years for hospitalization for non-fatal injury, the Hawaii rate (149.1 per 100,000) is lower than the national rate (166.4). Higher Hawaii rates are associated with age <1 year (182.3) and 1-4 years (168.9), race/ethnicity non-Hispanic Asian/Pacific Islander (300.3) and Non-Hispanic White (178.5), and males (161.6). For adolescents age 10-19 years for hospitalization for non-fatal injury, the Hawaii rate (212.4) is lower than the national rate (249.9). Higher Hawaii rates are associated with age 15-19 years (290.8), race/ethnicity non-Hispanic Asian/Pacific Islander (323.6) and non-Hispanic white (382.1), and males (272.5). (Data source: FAD/SID 2012)
FHSD Role: Family Support and Violence Prevention Section has a role related to non-fatal injuries due to child abuse and neglect that result in hospitalization.
FHSD Resources: See resources for Child Abuse and Neglect Prevention.
Community Alignment: DOH Injury Prevention and Control Section is the lead agency for injury prevention throughout the state for all age groups. Hawaii Injury Prevention Plan, 2012-2017, includes recommendations for violence and abuse prevention.
Hawaii Title V priority issue? – Met all criteria.

Physical Activity

Regular physical activity is essential in improving the health and quality of life for children and adolescents. It can reduce the risks for cardiovascular disease, hypertension, type 2 diabetes, and osteoporosis later in life.
Data: For children age 6-11 years with physical activity at least 60 minutes per day, the Hawaii rate (39.2%) is higher than the national rate (35.6%). For adolescents age 12-17 years, the Hawaii rate (18.3%) is lower than the national rate (20.5%). (Source: FAD/NSCH 2011/12)

FHSD Role: FHSD does not have a lead role, but works on this issue as part of early childhood and adolescent wellness.
FHSD Resources: Limited. ECCS Coordinator is co-lead for the Early Childhood Action Strategy on On-track Health and Development workgroup, which is developing Early Childhood Health and Wellness Guidelines which include physical activity. The Adolescent Coordinator is the lead for adolescent well-being.
Community Alignment: DOH Chronic Disease Prevention and Health Promotion Division is the lead for Physical Activity and Nutrition (Hawaii Health Initiative). Hawaii Physical Activity and Nutrition Plan 2013-2020 includes objectives regarding comprehensive Health and Physical Education in Department of Education (DOE) schools, and includes physical activity in child care license requirements and wellness guidelines. Hawaii Coordinated Chronic Disease Framework has an objective that educational settings establish comprehensive policies and environments that include supporting daily physical activity for all students.
Hawaii Title V priority issue? – Did not meet criteria for FHSD role or resources.

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

ADOLESCENT HEALTH

Adolescent Well-Visit

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

Bullying

Bullying experiences are associated with behavioral and emotional problems for both those who bully or are victims of bullying. Problems may continue into adulthood and may have long-term impact.
Data: For adolescents age 12-17 years who are bullied or who bully others, FAD/NSCH 2011/12 data show that the Hawaii rate (15.4%) was comparable to the national rate (14.2%). The FAD/YRBSS 2013 Hawaii rate (25.8%) was also comparable to the national rate (25.2%).
FHSD Role: Limited. However, FHSD works on this issue as part of adolescent wellness.
FHSD Resources: Limited.
Community Alignment: DOE is working to reduce bullying and cyberbullying in various ways including: implementing school-wide positive behavior practices; anti-bullying program; community partnerships; identifying, monitoring, and tracking student concerns; and supporting victims and bullies to address ongoing conditions. The 2015 State Legislature had several bills on anti-bullying efforts.
Hawaii Title V priority issue? – Did not meet criteria for FHSD role or resources.

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

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Transition to Adult Health Care

Health and health care are major barriers to making successful transitions. Youth with special health care needs, compared to those without special health care needs, are less likely to complete high school, attend college, or be employed.
Data: For adolescents with special health care needs who received services necessary to make transitions to adult health care, the Hawaii rate (37.3%) is lower than the national rate (40.0%). Hawaii rates are lower for males (33.3%). (Source: FAD/NSCSHCN 2009/10)
FHSD Role: Children and Youth with Special Health Needs Section (CYSHNS) currently leads program effects related to transition (e.g., quality improvement) and has leadership roles in planning transition fairs with state/community partners.
FHSD Resources: CYSHNS staff on Oahu and the Neighbor Islands of Hawaii, Maui, and Kauai are involved in transition activities. CYSHNS staff will work with the Adolescent Coordinator on the issue of adolescent well-visits, since it may impact the issue of transition to adult health care. Genomics Section Supervisor is the lead for the Western States Genetic Services Collaborative which includes a priority to support transition from pediatric to adult services.
Community Alignment: AAP-Hawaii Chapter priorities for 2015 and beyond include transition of adolescents to adult care with a focus on youth with special health care needs. Hilopaa F2FHIC provides education and developed materials to support the transition to adult health care. Transition fair planning has involved CYSHNS, Community Children's Council Office, DOH/Developmental Disabilities Division, Hawaii MCH LEND Program, Hawaii State Council on Developmental Disabilities, DOE, Hilopaa F2FHIC, Special Parent Information Network, and other agencies/organizations. DOH Child and Adolescent Mental Health Division Strategic Plan 2015-2018 includes an objective to collaborate with partner state agencies to develop and implement a plan to improve the Hawaii system of care to address the needs of transition-age youth with mental health challenges; this issue was raised during public hearings. Hawaii State Council on Developmental Disabilities 2012-2016 State Plan includes a goal about preparing students at all educational levels for the transition from high school to adult life including employment, self-employment, and/or post-secondary education and training.
Hawaii Title V priority issue? – Met all criteria.

Medical Home

Children with medical homes are more like to receive preventive health care, have fewer hospitalizations for preventable conditions, and have early diagnosis for chronic conditions/special health care needs.
Data: For children with a medical home, the Hawaii rate (57.4%) is higher than the national rate (54.4%). The Hawaii medical home rate for children with special health care needs (43.3%) is lower than the rate for children without special health care needs (60.4%). (Data source: NSCH 2011/12)
FHSD Role: Children and Youth with Special Health Needs Section is not involved in medical home practice changes for primary care providers. However, CYSHNS supports medical homes by working to increase access to services, such as legislative mandates for insurance coverage for orthodontic services for children with orofacial conditions or hearing aids for children with hearing loss. CYSHNS also assists families with service coordination, social work, nutrition services, financial assistance for medical specialty services, and pediatric clinics on the Neighbor Islands where services are not available.
FHSD Resources: FHSD resources are program-specific. Newborn Metabolic Screening and Newborn Hearing Screening Programs support the medical home by helping to identify newborns who require follow-up and coordination of referrals and services. Early Intervention Section invites the child's medical home providers to Individual Family Support Plan meetings. Genetics Program supports the medical home by increasing access to genetic services in the community, offering outreach clinics to Neighbor Islands and providing telegenetics activities.
Community Alignment: The medical home concept for children is promoted by AAP-Hawaii Chapter and University of Hawaii School of Medicine/Department of Pediatrics. AAP-Hawaii Chapter, with Hilopaa F2FHIC, collaborated with the State's largest insurance payer to develop a pediatric patient-centered medical home (PCMH) model, which

provides enhanced payments to physicians who improve quality of care. The largest insurance payer adopted the PCMH model for primary care providers as its value-based health care initiative. Hawaii Primary Care Association facilitates continuous quality improvement programs in Hawaii's community health center network, including the development of PCMH.

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

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

CROSS-CUTTING OR LIFE COURSE

Oral Health

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

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

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

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

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

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

Hawaii Title V priority issue? – Met all criteria.

Access to Services through Telehealth

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

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

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

FHSD Resources: FHSD staff can work with University of Hawaii and Pacific Basin Telehealth Resource Center to maximize resources (broadband connections, equipment, training, technical assistance) available and apply for

additional funding if needed. Policies and procedures for implementing HIPAA compliance and evaluation methods are already available for telehealth activities. Early Intervention Section is interested in providing tele-early intervention services.
Community Alignment: State of Hawaii Community Health Needs Assessment notes that fewer services are available in rural parts of Oahu and Neighbor Islands, and that many specialized services are not available on each island, requiring costly air transportation to receive needed care. Hawaii State Council on Developmental Disabilities 2012-2016 State Plan includes an activity to pursue statewide telemedicine opportunities. The legislature supports telehealth as evidenced by Act 159 (2014) which mandated reimbursement parity for face-to-face and telehealth visits provided by health care providers. In Genetic Program surveys of Neighbor Island families receiving genetic services via videoconferencing, 20% families reported that they would not have sought genetic services if telehealth had not been an option.
Hawaii Title V priority issue? – Met all criteria.

Smoking

Smoke during pregnancy may increase the risk for fetal death or low birth weight baby. Children exposed to secondhand smoke in their homes have more ear infections, respiratory illnesses, severe asthma, and other medical needs.
Data: FAD data for Hawaii on the percent of women who smoke during pregnancy is not available.
For children who live in households where someone smokes, the Hawaii rate (25.7%) is slightly higher than the national rate (24.1%). (Data source: FAD/NSCH 2011/12)
FHSD Role: FHSD does not have a lead role, but contributes as part of the Hawaii MIH Collaborative.
FHSD Resources: FHSD staff are active participants of the Hawaii MIH Collaborative.
Community Alignment: Hawaii MIH Collaborative's strategic plan includes smoking cessation as part of promoting healthy behaviors across the life span, appropriate care for mothers at risk, and healthy behaviors in at-risk populations. The DOH lead on smoking is the Tobacco Prevention and Education Program which uses prevention and education approaches for activities focusing on youth, second hand smoke, smoking cessation, and disparate populations.
Hawaii Title V priority issue? – Did not meet criteria for FHSD role or resources.

Adequate Insurance Coverage

Inadequately insured children are more likely to delay or forego care, lack a medical home, be less likely to receive needed referrals and care coordination, and receive family-centered care.
Data: For children ages 0-17 years who are adequately insured, the Hawaii rate (81.2%) is higher than the national rate (76.5%). (Data source: FAD/NSCH 2011/2012)
FHSD Role: FHSD is not the lead for this area. However, CSHN Branch programs contribute to adequate insurance coverage in specific areas.
FHSD Resources: Resources are limited to specific areas. Working with community partners, the CYSHNS assisted in legislative efforts to mandate insurance coverage of orthodontic services for children with orofacial conditions, and coverage of hearing aids for individuals with hearing loss. Genetics and Newborn Metabolic Screening Programs work with families and third-party payers on improving the process for coverage and reimbursement of medical formulas and foods. Genetics Program works with genetics specialists and third-party payers to improve the approval process and reimbursement for genetic services.
Community Alignment: State of Hawaii Community Health Needs Assessment notes that while health insurance in Hawaii is better than the U.S., other access issues include fewer health services in rural parts of Oahu and neighboring islands and that many specialized services are not available on each island.
Hawaii Title V priority issue? – Did not meet criteria for FHSD resources.

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

SUMMARY OF HAWAII TITLE V PRIORITY ISSUES

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

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

II.B.2.b Title V Program Capacity

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

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

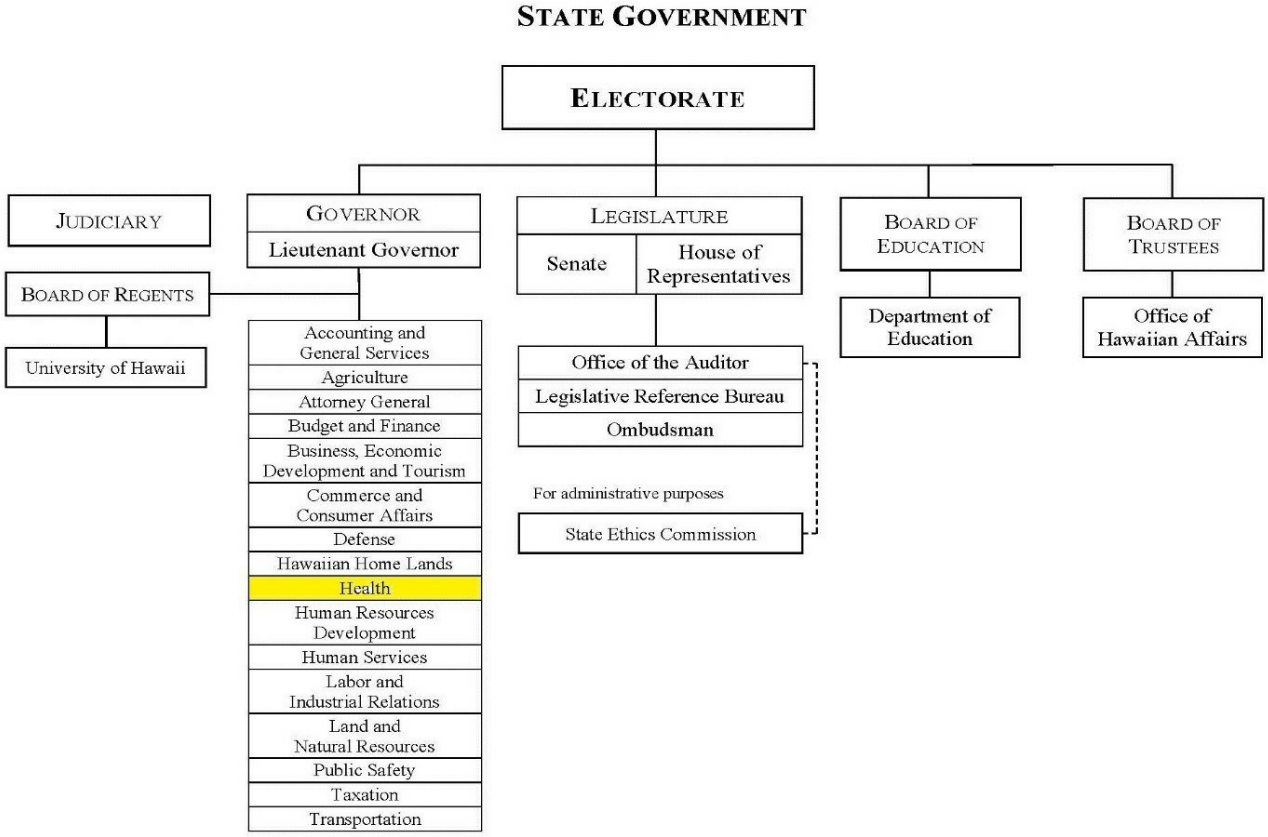


Figure 1

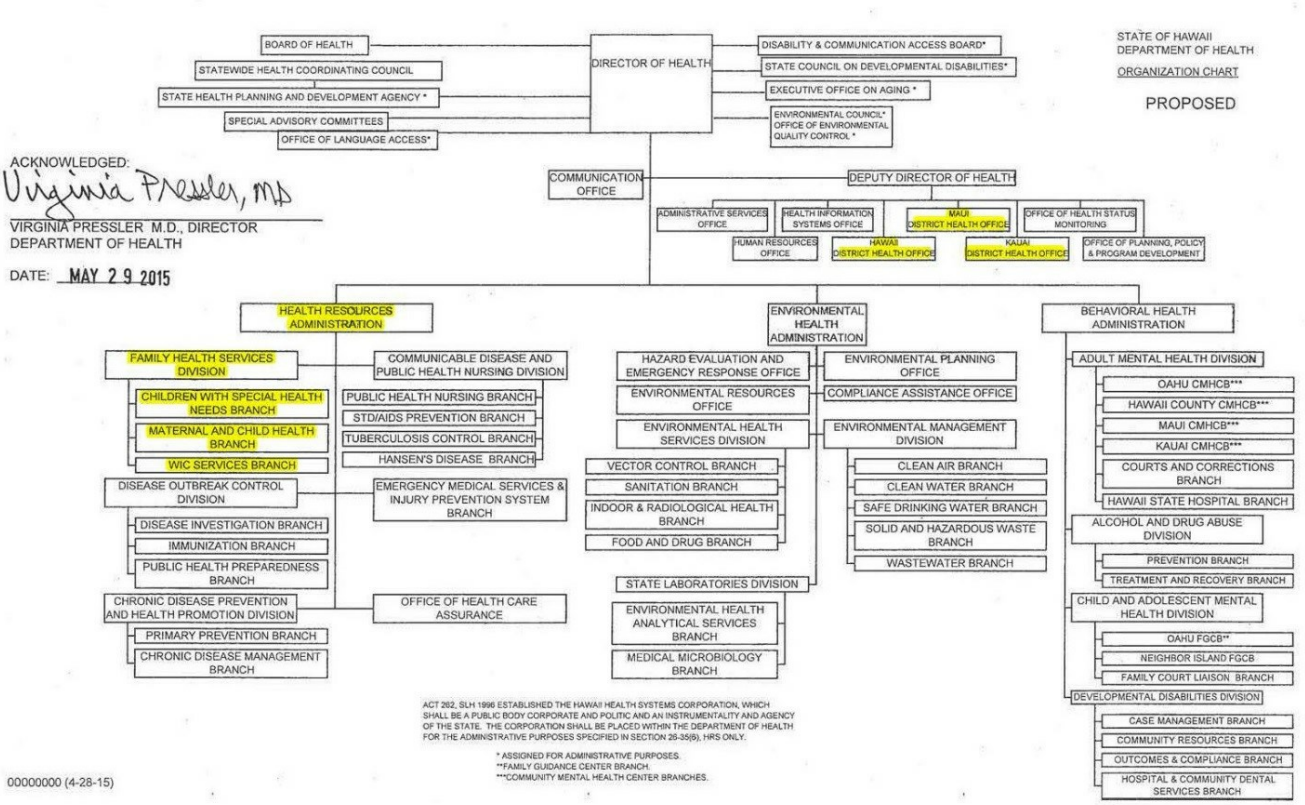


Figure 2

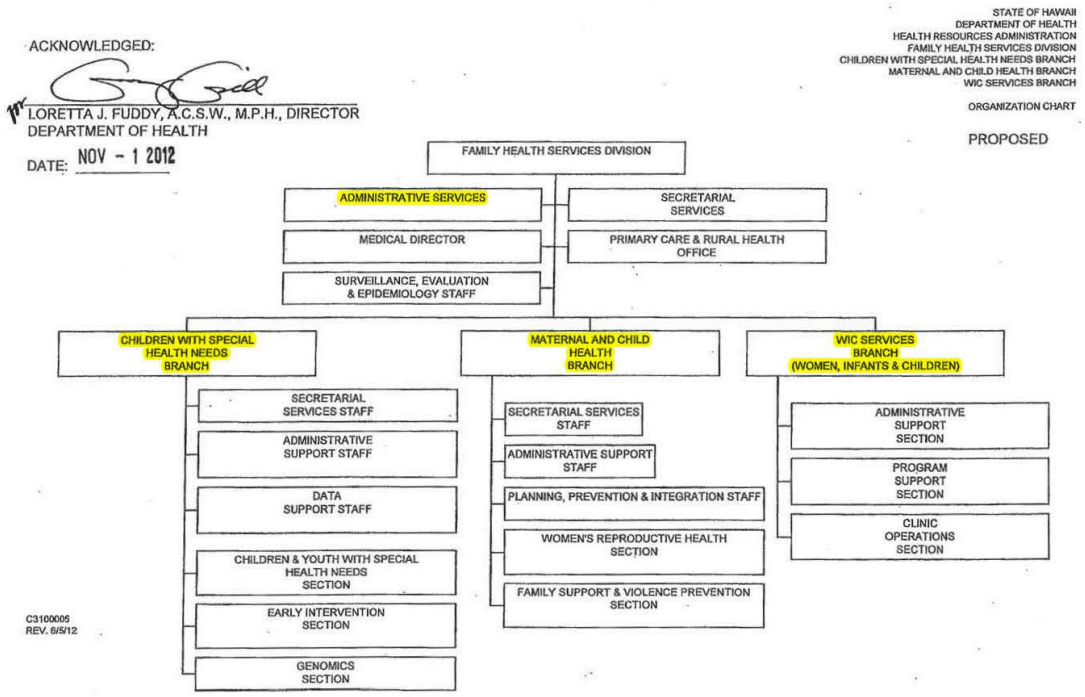

ACKNOWLEDGED:
LORETTA J. FUDDY, A.C.S.W., M.P.H., DIRECTOR
DEPARTMENT OF HEALTH
DATE: NOV - 1 2012
STATE OF HAWAII
DEPARTMENT OF HEALTH
HEALTH RESOURCES ADMINISTRATION
FAMILY HEALTH SERVICES DIVISION
CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH
MATERNAL AND CHILD HEALTH BRANCH
WIC SERVICES BRANCH
ORGANIZATION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

Figure 3

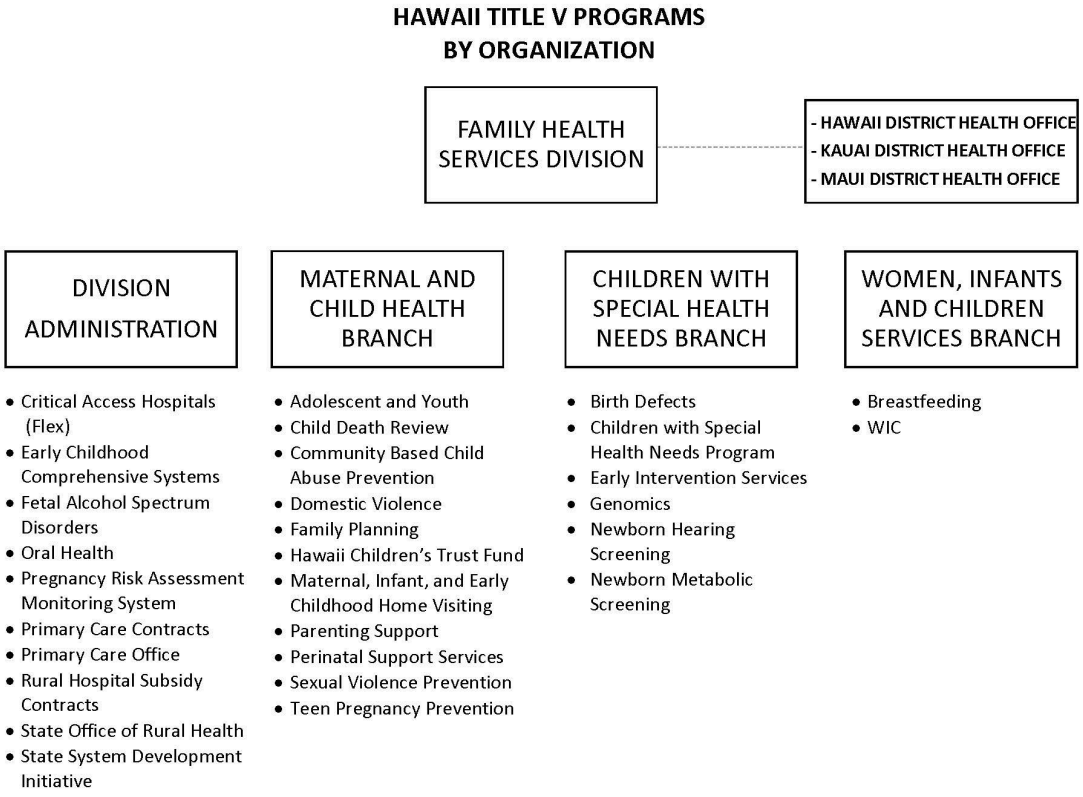


Figure 3.a.

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

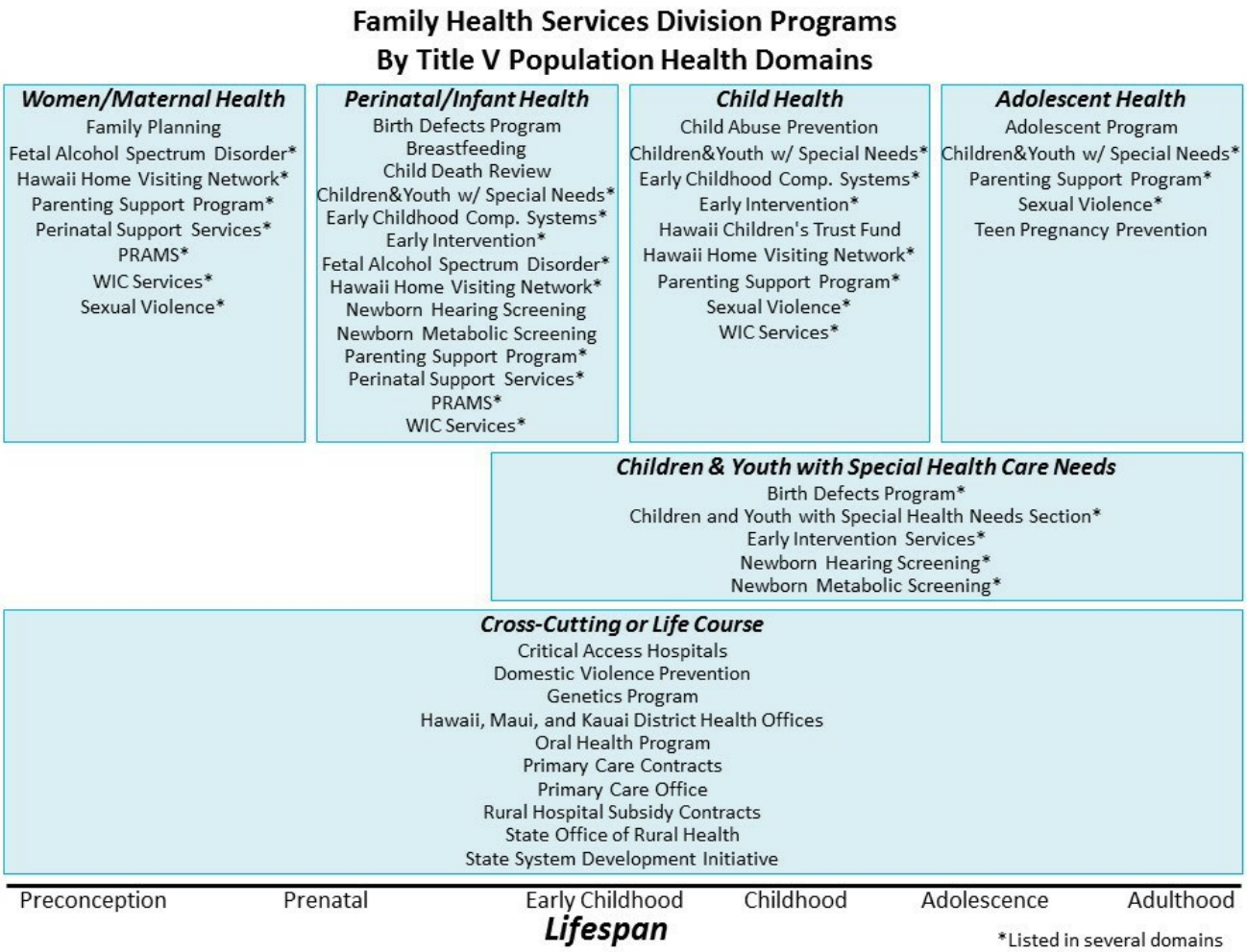
STATE'S CAPACITY TO PROMOTE AND PROTECT THE HEALTH OF MOTHERS AND CHILDREN, INCLUDING CSHCN

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

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

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

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



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

ENSURING A STATEWIDE SYSTEM OF SERVICES

State program collaboration with other agencies: Collaborations include:

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

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

- Informing, educating and empowering through partnerships and public awareness campaigns such as Child Abuse Neglect Prevention and Child Abuse Prevention, Fetal Alcohol Spectrum Disorders, Women's Health Month, Children and Youth Month, and Safe Sleep.

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

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

State support for communities. Examples include:

- FHSD coordinators in each DHO promote MCH/CSHCN public health activities on Neighbor Islands.

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

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

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

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

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

- Contracts with Community Health Centers support access to prenatal care and other medical and dental services at the community level.

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

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

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

- DHO Family Health Services Coordinators work with their communities to coordinate health and other services.

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

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

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

MCH AND CSHCN WORKFORCE

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

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

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

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

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

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

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

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

- TITLE V FAMILY LEADER: Leolinda Parlin has been active in the needs assessment process and planning of Title V MCH/CSHCN priorities and activities for many years. She is the parent of a young man with special

needs; Director, Hilopaa F2FHIC; Co-Director, Hawaii MCH LEND Program; Coordinator, Family Voices of Hawaii; Family Delegate, Association of MCH Programs.

Needs and challenges:

- Vacancies for key leadership positions, with a lengthy hiring process.
- Difficulty in filling Title V funded positions, due to insufficient Title V funding.There has not been an increase in Title V funding to correspond with salary increases.
- Difficulty in requesting new State general funded positions due to State economic concerns.
- Difficulty in filling federal grant funded positions due to a lengthy process.
- FHSD is still adjusting to the loss of a significant number of positions with the Reduction in Force of 2009 and other personnel action, which resulted in the abolishment of 76.75 permanent positions within FHSD (21.0% staffing reduction).

CULTURALLY COMPETENT APPROACHES

Promoting culturally competent approaches in service delivery include:

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

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

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

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

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

Other federal investments:

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

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

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

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

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

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

- Public Health Nursing Branch is a partner in many initiatives since many nurses work in the community and are available statewide.
- Chronic Disease Prevention and Health Promotion Division has been instrumental in reducing obesity through the joint promotion of physical activity, breastfeeding, and early childhood health and wellness.

- Immunization Branch works with FHSD to promote the importance of vaccinations and pandemic flu preparedness.

- Office of Health Status Monitoring works with FHSD statisticians and MCH Epidemiologist on use of vital statistics data for program planning and improvement.

- Child and Adolescent Mental Health Division facilitates the Hawaii Interagency State Youth Network of Care, in which the Early Intervention Section participates.

- Developmental Disabilities Division coordinates with CSHN Branch related to services for young children with developmental delays

- Injury Prevention coordinator and staff work with many FHSD programs to address injury prevention.

- Hazard Evaluation and Emergency Response Office collaborates with FHSD staff on lead poisoning prevention.

Other government agencies: FHSD works with other departments including:

- Department of Education (DOE):Hawaii has a single unified public school system serving kindergarten to grade 12.Many FHSD programs work with the DOE on priorities for children (developmental screening, vision screening, and child abuse and neglect), adolescents (wellness), youth with special health care needs

(transition to adult life), and life course (oral health).WIC serves with representatives from DOE Office of Hawaii Child Nutrition Programs on various committees. WIC works with DOE School Food Services to coordinate the amount of formula provided by DOE versus WIC. Early Intervention Section works with DOE on the transition of young children from early intervention to DOE preschool special education.

- Department of Human Services (DHS): FHSD representative sits on the DHS Child Care Advisory to discuss the Child Care Development Block grant. Many FHSD staff and Neighbor Island nurses serve on the DHS Child Welfare Advisory committees. FHSD representatives are on the Early Periodic Screening Diagnosis and Treatment (EPSDT) Advisory Committee. A DHS-DOH Memorandum of Agreement provides Medicaid reimbursement to FHSD for early intervention services for QUEST-eligible infants and toddlers who have a developmental delay or biological risk (see Agreement in Section IV).

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

Family/consumer partnership and leadership programs:

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

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

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

Other public and private organizations that serve the MCH population include: American Academy of Pediatrics–Hawaii Chapter, community health centers, Hawaii MCH LEND, Hawaii Dental Association, Hawaii

Primary Care Association, Healthy Child Care Hawaii, Healthy Mothers Healthy Babies, Hilopaa F2FHIC, hospitals/birthing facilities, March of Dimes, and many others.

II.C. State Selected Priorities

No.	Priority Need	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	

How Priority Needs were Determined

Since the last 5-year needs assessment, FHSD has suffered a significant loss of staffing (20% reduction) and funding, with the elimination of programs and reductions in program eligibility and benefits. This contraction of organizational capacity has occurred at a time of increasing demand for services resulting in a general sense of “overwhelm” among staff. Thus, FHSD conducted the needs assessment cognizant of strategically leveraging existing resources; building upon established collaborative initiatives; capitalizing on partnerships; and developing capacity by building on current programs, initiatives and strategies. Using this approach FHSD was able to reduce duplication of assessment efforts on a small state population, and assure Title V priorities and plans were well-aligned with key partners in public health and the health care system.

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

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

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

The MCH issues that FHSD selected for review were based on six population health domains and link to Title V National Performance Measures, current State priorities, or emerging issues. It was expected that both the state priority and its related National Performance Measure must meet the same selection criteria.

Change in State Priority Needs

Priority Needs 2011-2015	Priority Needs 2016-2020	Comment
Reduce the rate of unintended pregnancy CONTINUED	Promote reproductive life planning	Renamed/expanded broader approach, including also promoting preconception health care visits andhealthy behaviors.
Reduce the rate of alcohol use during pregnancy REPLACED		FHSD no longer has a Fetal Alcohol Spectrum Disorder (FASD) Coordinator position. Work on this area continues with the Hawaii Maternal and Infant Health Collaborative.
	Reduce the rate of infant mortality by improving breastfeeding rates and promoting safe sleep practices. **NEW**	Met the selection criteria.
Reduce the rate of overweight and obesity in young children ages 0-5 REPLACED		FHSD does not have a lead role. DOH Chronic Disease Prevention and Health Promotion Division is the DOH lead for Physical Activity and Nutrition.
Improve the percentage of children age 0-5 years screened early and continuously for developmental delay	Improve the percentage of children age 0-5 years screened early and continuously for developmental delay	

Priority Needs 2011-2015	Priority Needs 2016-2020	Comment
CONTINUED		
Reduce the rate of child abuse and neglect with special attention on ages 0-5 years CONTINUED	Reduce the rate of child abuse and neglect with special attention on ages 0-5 years	
	Improve the healthy development, health, safety, and well-being of adolescents **NEW**	Met the selection criteria.
Improve the percentage of youth with special health care needs age 14-21 years who receive services necessary to make transitions to adult health care CONTINUED	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	
Improve the oral health of children age 0-18 years CONTINUED	Improve the oral health of children and pregnant women	Pregnant women were added to be more aligned with the National Performance Measure
	Improve access to services through telehealth **NEW**	Met the selection criteria.

Outcome Measures

Addressing several state priorities may contribute to improving National Performance Measures that may impact specific outcomes that are of concern to Hawaii.

Severe maternal morbidity (National Outcome Measure for NPM 1): Rates of severe maternal morbidity have increased steadily from 2008 when there were 73.5 per 10,000 births to 131.2 in 2012. FHSD has been involved with discussions with representatives from American College of Obstetricians and Gynecologists (ACOG) and the University of Hawaii/School of Medicine about further evaluation of these trends and possible implementation of a maternal mortality review. Of concern is that these rates do not include births that occurred in the primary military hospital in Hawaii, which accounts for about 15% of all births in Hawaii.

Perinatal and infant mortality rates (National Outcome Measure for NPM 1, 4, and 5): In 2013, there were increases in the perinatal and infant mortality rates compared to the prior two years which were at historical lows. The perinatal rate increased from 5.4 per 1,000 live births and fetal deaths to 6.7. The infant mortality rate increased from 4.9 per 1,000 live births in 2012 to 6.4 in 2013 due to an increase in 29 infant deaths. This was predominantly due to increases seen in the neonatal period where the rate increased from 3.6 to 4.6, rather than the post-neonatal time period which demonstrated a smaller increase 1.3 to 1.8. This increase was predominantly due to increases in congenital anomalies and preterm-related mortality. There are substantial ongoing efforts through the

Hawaii Maternal and Infant Health Collaborative to address infant mortality. In preliminary 2014 data, the overall infant mortality rate declined to 4.8 per 1,000 live births. Ongoing work in the Collaborative include efforts to promote long acting reversible contraception post-pregnancy; promote utilization of Screening Brief Intervention and Referral to Treatment for smoking, alcohol, and other substances during pregnancy; promote utilization of 17-progesterone to prevent preterm births; and promote safe sleep activities.

Neonatal abstinence syndrome is a related outcome. The rate of infants born with neonatal abstinence syndrome has seen a steady increase since 2008 when the rate was 1.8 per 1,000 hospitalizations for live births to a rate of 2.5 in 2012, which represented 39 infants with the diagnosis. FHSD has been involved with partners to further evaluate these trends, including potential differences by race and geographic regions in Hawaii.

Child mortality rate (National Outcome Measure for NPM 7): The overall child mortality rate for ages 1-9 years has increased from 10.9 per 100,000 children in 2012 to 20.2 in 2013, which is similar to estimates from 2009 when the rate was 19.3. Further evaluation of these trends is needed and will involve discussion with partners. There are efforts to restart the child death review process that has been inactive due to staff shortages since 2013 where these causes could be reviewed.

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

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	65.0	65.0	65.0	65.0	65.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	94.0	94.0	94.0	94.0	94.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	28.0	28.0	28.0	28.0	28.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	82.0	82.0	82.0	82.0	82.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	41.0	41.0	41.0	41.0	41.0

Annual Objectives					
	2016	2017	2018	2019	2020

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	142.0	142.0	142.0	142.0	142.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	86.0	86.0	86.0	86.0	86.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	39.0	39.0	39.0	39.0	39.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.0	45.0	45.0	45.0	45.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	87.0	87.0	87.0	87.0	87.0

Domain	State Priority	Related National Performance Measure (NPM)	Rationale for Selection of NPM
Women's/ Maternal Health	Promote reproductive life planning	NPM 1 – Percent of women with a past year preventive medical visit	Preventive health visits help women to adopt or maintain healthy habits and behaviors, detect early and treat health conditions, plan for a healthy pregnancy, and consider reproductive life planning.
Perinatal/ Infant Health	Reduce the rate of infant mortality by improving breastfeeding rates and promoting safe sleep practices	NPM 4 – A) Percent of infants who are ever breastfed. B) Percent of infants breastfed exclusively through 6 months.	Breastfeeding has been shown to lower the risk of Sudden Infant Death Syndrome. Health advantages of breastfeeding include nutritional, immunological and psychological benefits to both mother and infant as well as economic benefits.
		NPM 5 – Percent of infants placed to sleep on their backs.	Sleep-related deaths are the leading cause of infant death after the first month of life and the third leading cause of infant death overall.
Child Health	Promote early childhood screening and development	NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool.	Screening is important for the early identification of developmental concerns and appropriate follow-up, including referrals to early intervention or special education services.
	Prevent child abuse and neglect	NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children	Injuries are the leading cause of death among children. Non-fatal injuries

Domain	State Priority	Related National Performance Measure (NPM)	Rationale for Selection of NPM
		age 0 through 9 and adolescents age 10 through 19.	due to child abuse and neglect may result in hospitalization.
Adolescent Health	Promote adolescent well-being	NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	Preventive health visits help adolescents adopt or maintain healthy habits and behaviors, manage their health and health care, manage chronic conditions, and plan their transition to adult health care.
Children with Special Health Care Needs	Promote transition to adult health care	NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care.	Health and health care are major barriers to making successful transitions. Youth with special health care needs, compared to those without special health care needs, are less likely to complete high school, attend college, or be employed.
Cross-Cutting or Life Course	Improve oral health	NPM 13 – A) Percent of women who had a dental visit during pregnancy. B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.	Access to oral health care is essential to reduce the risk of oral diseases. Without treatment, dental decay can cause pain and infection that can compromise a child's ability to eat, school attendance, and ability to concentrate and learn in the classroom.
	Improve access to services through telehealth	None – a state performance measures will be developed	

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

Measures

FHSD will identify and establish three to five state performance measures and their performance objectives as part of the FY 2017 Application/ FY 2015 Annual Report and will begin submission of state performance data starting with the FY 2016 Annual Report.

New State Priority: Improve Services through Telehealth

A state performance measure will be established for this new priority. 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 time and money.

The legislature is supportive of telehealth as evidenced by the passage of Act 159 (2014) which mandated reimbursement parity for face-to-face and telehealth visits provided by health care providers. Health care providers are defined as primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians, advanced practice registered nurses, psychologists, and dentists.

The use of telehealth in Title V programs can show great change in the next 5 years if effort and resources are put towards this activity.

II.F. Five Year State Action Plan

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

INTRODUCTION

The FY 2014 annual report for the 2011-2015 National and State Performance Measures is presented by population domain. The plan narratives address the eight new/continuing National Performance Measures by population domain as reflected in the state five year plan table. Hawaii is using the plan template provided by Title V. The narratives review the information in the plan table as well as discuss specific plans for the application year (FY 2016). State performance measures, evidence based/informed strategy measures will be completed in next year's report.

For the FY 2014 annual report, there is little change or no new data for most of the 2011-2015 National (NPM) and State Performance Measures (SPM):

- Women/Maternal Health: there is no new data available for the current year (due to delay in PRAMS data) other than for NPM 18 (based on vital statistics); however, the estimate for NPM 18 is not comparable to previous years due to the adoption of the 2003 birth certificate revision in 2014.
- Perinatal/Infant Health: there have been no substantial changes in the NPMs.
- Child Health: there has been no change in the measures where new data was available.
- Adolescent Health: there has been continued improvement in teen births as well as a reduction in the rate of teen suicide deaths.
- CSHCN Health: There is no new data available (all from CSHCN survey).
- Cross-Cutting/Life Course: There is no new data available (YRBS) for the SPM child oral health measure.

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Promote reproductive life planning	By July 2020, increase the percent of women with a preventive medical visit in the last year to 65% (Baseline: 2013 BRFSS data 62.3%)	• Promote preconception health care visits (e.g. identify access barriers, community and provider education, public awareness) • Promote reproductive life planning (e.g. increase birth spacing,	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very	Percent of women with a past year preventive medical visit		

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		improve access to family planning) • Promote healthy behaviors (e.g. smoking cessation, decrease alcohol and substance use, maintain healthy weight, use of folic acid, chronic disease control)	low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related			

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			mortality rate per 100,000 live births			

Women/Maternal Health

Women/Maternal Health - Plan for the Application Year

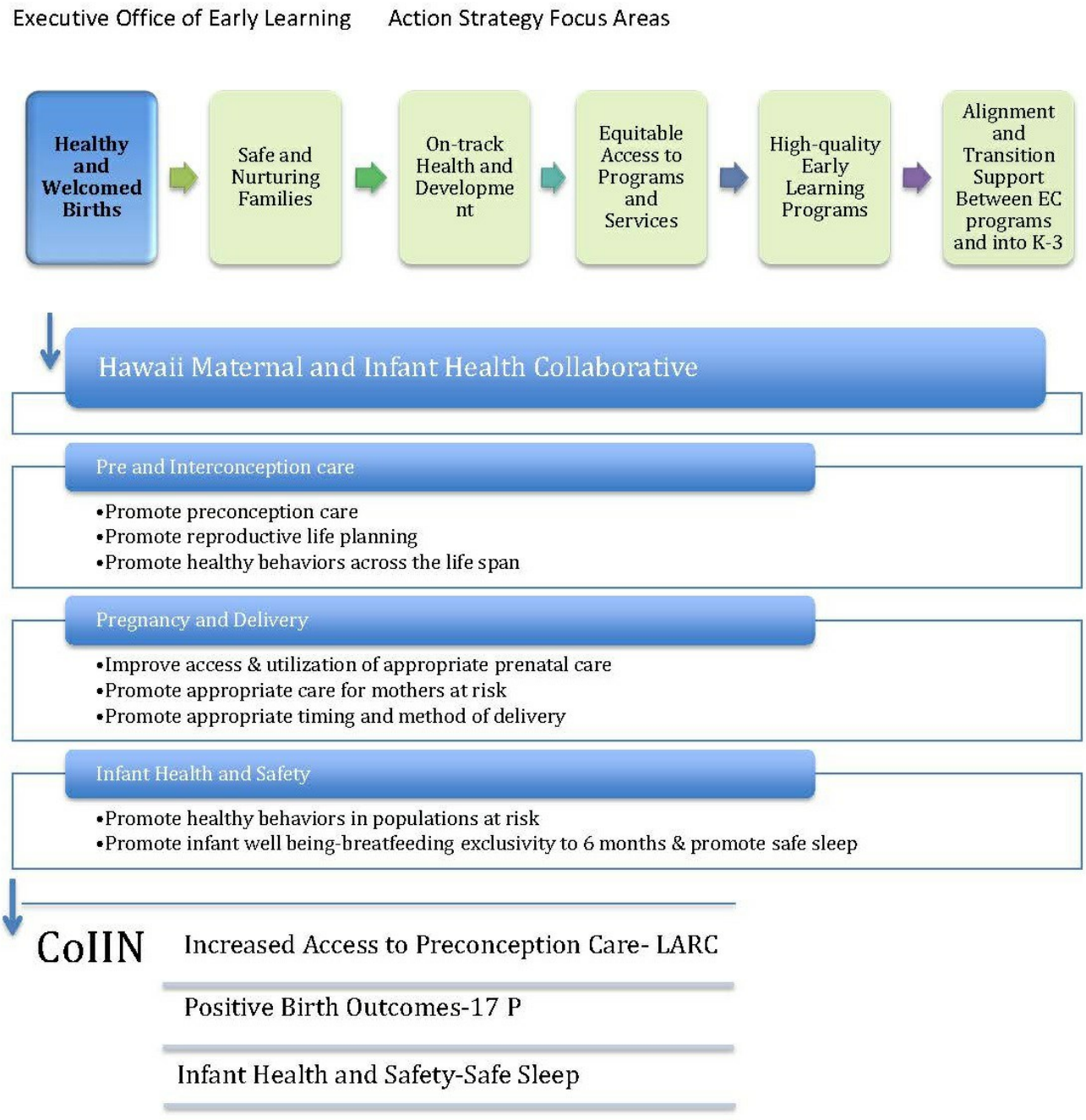
Preliminary 5-Year Plan:
The 5-year needs assessment affirmed the importance of women's prevention health care as a priority issue based on the work of:

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

The Title V agency applied for and received the NGA Learning Network technical assistance (TA) to improve Birth Outcomes. The application was developed in conjunction with the March of Dimes Hawaii Chapter. This included Hawaii team participation in a Washington, DC August 29-30, 2013 Learning Network Conference on Improving Birth Outcomes to assist states in developing, implementing and aligning their key policies and initiatives related to the improvement of birth outcomes. The Conference also allowed for states selected to share with one another lessons learned and to further their respective planning processes This TA was then used to kick-off and support a series of planning sessions in 2013 to engage a broad group of stakeholders in strategic thinking about a comprehensive approach to improving birth outcomes in Hawaii. This effort was conducted in partnership with the Executive Office of Early Learning's Action Strategy initiative which included a workgroup on "Healthy and Welcomed Births." The HMIHC was formed to sustain the planning and implementation work begun through NGA TA. HMIHC completed a strategic plan and Logic Model, *The First 1,000 Days*, aimed at achieving the outcomes of 8% reduction in preterm births and 4% reduction in infant mortality by 2020.
To date over 80 people across Hawaii have been involved in the HMIHC. These members include physicians and clinicians, public health planners and providers, insurance providers and health care administrators.
Women's preventive health is viewed as a critical factor to reducing infant mortality and improving birth outcomes. Thus, the HMIHC has a work group focused on preconception and interconception care which specifically focuses on the health of reproductive aged women.
Subsequently, the State participated in the July 2015 Infant Mortality CoIIN Summit and has utilized the strategic goals set by the HMIHC to select CoIIN projects for Hawaii. Hawaii has drawn from the HMIHC to provide leadership and direction for CoIIN projects. Each project has a Department of Health (DOH) and community partner as co-leaders.
Priority: Improve reproductive life planning
The HMIHC goals for women's preventive health are to reduce unintended pregnancy and improve birth spacing –

the improvement of reproductive life planning. This priority supports the efforts of the Infant Mortality CoIIN project activities which are focusing on Long Acting Reversible Contraception (LARC), as an evidence based strategy. Reducing the rate of unintended pregnancy also served as the state Title V priority from the previous 5-year project period. Expanding the focus on women's preventive health overall is a new Title V priority for Hawaii. Administratively, the Title V agency has always recognized the importance of women's health. Perinatal support and federal Title X funded family planning programs are housed in the "Women's and Reproductive Health Section" of the Maternal and Child Health Branch under Title V. Regrettably, staff and budget reductions over the past six years have prevented the Section from realizing its broader mission to improve women's health.

How it all Connects



Objective:

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

National Performance Measure: Percent of women with a past year preventive medical visit

The state priority is based on the Title V block grant guidance National Performance Measures (NPM) for women's

health. The HMIHC identified several objectives relating to women's preconception and interconception health which do not include the Title V NPM for women's health. Discussions were conducted with the Title V women's health program staff, the CoIIN project team, and HMIHC leadership group to determine the best alignment between the HMIHC plan, the Hawaii CoIIN projects, and Title V women's health program resources. The consensus was to select the Title V NPM to increase preventive medical visits and develop a preliminary objective around the NPM. Discussions will continue to consider formal integration of the Title V measure into the existing HMIHC strategic plan and logic model.

5-Year Strategies:

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

Strategy Development

These strategies are from the HMIHC Pre and Interconception work group. The group meets monthly and works in coordination with the CoIIN project team focusing on promotion of LARC. Implementation activities will be developed in partnership with Collaborative members including March of Dimes Hawaii Chapter, Medicaid, Governor's Office on Health Care Transformation, Hawaii American Congress of Obstetricians and Gynecologists, Hawaii Section (Hawaii ACOG), and the University of Hawaii John A Burns School of Medicine (JABSOM).

Plans for Application Year Federal Fiscal Year 2016 (10/1/15-9/30/16):

- Clarify policies for Medicaid and private insurance on LARC reimbursement immediately postpartum prior to discharge, and outpatient for women of reproductive age if requested
- Assess need for provider training on changes to LARC coverage and codes
- Increase provider competency with the provision of training
- Increase voluntary utilization of LARC in our adolescent population
- Assess if barriers have been reduced (e.g. availability of pharmacy stock for hospital inpatient)

Increasing access to and utilization of LARC both postpartum and for the population in general including adolescents when wanted was identified as a priority by the HMIHC and was thus selected as a CoIIN project. Specific action steps were identified to implement Increase LARC usage over the next two years.

During September 2014 the HMIHC developed a white paper on Medicaid and Insurance Reimbursement for Immediate Post-Partum Long Acting Reversible Contraception. This was used to support discussion and improvement for billing and reimbursement for LARC immediate post-partum and support the reduction of unintended pregnancy.

During June 2015, a new intrauterine device (IUD) became approved by the Federal Drug Administration and available to all Title X family planning providers at a lower cost with 340-B. On April 7, 2015, the Centers for Disease Control and Prevention released a Morbidity and Mortality Weekly Report, Vital Signs: Trends in Use of Long-Acting Reversible Contraception Among Teens Aged 15-19 Years Seeking Contraceptive Services – United States, 2005-2013. The State of Hawaii was fifth for the percentage of female teen's aged 15-19 using LARC among those seeking contraceptive services at Title X service sites, by state. It should be noted though that the number of teens seen at Title X clinics is small and not representative of the State as a whole (for the Vital Signs report there were 2,787 teens using LARC during 2005 – 2013). This does though demonstrate that there is Title X provider comfort in provision of LARC although this may vary by service site, and there has been available a variety of resources for statewide LARC training since 2009 for Title X sub-recipients.

The Hawaii Department of Health (DOH) and its Title X family planning grant in partnership with the preventive health care services block grant will hold a reproductive health training for its family planning providers on 10/23/2015. This

training will include a session on adolescent counseling and a LARC practicum for IUD for clinicians. The session will support the dissemination of information including that LARC is safe for teens; training providers on using a client centered counseling approach in service delivery; LARC (IUD insertion) and, increasing awareness of LARC coverage. If completed by the date of this training the Hawaii LARC Reimbursement Guide that is being developed on both Medicaid and private reimbursement information for all Hawaii plans will also be distributed.
The HMIHC through its partnerships through Medicaid, Governor's Office on Health Care Transformation, and JABSOM will complete an assessment of Medicaid and Private Insurance policies related to reimbursement for LARC insertion immediately post-partum. This reimbursement information will be used to develop a Reimbursement Guide for providers that clarifies coverage for LARC by all Hawaii Medicaid and private health insurance plans. March of Dimes Hawaii Chapter has committed to fund the development and dissemination of the guide. The Guide will initially be distributed during the Hawaii ACOG annual meeting in November 2015. A presentation on the benefits of LARC will be conducted by faculty from JABSOM at the meeting. The presentation will also include information on clinical guidelines for adolescents and LARC insertion, as well as, a review of the Hawaii LARC Reimbursement Guide.
All training of providers on LARC insertion will include using a client centered approach that includes discussing the most effective methods of contraception and ensuring that decision making on use is voluntary, respectful of and responsive to individual preferences, needs, and values.
There will be two face-to-face meetings for up to 70 collaborative stakeholders including neighbor island representation held during FY 2016. The HMIHC will be involved in this planning with administrative support from a Maternal and Child Health contract with Healthy Mothers Healthy Babies Coalition of Hawaii. This will include discussion of opportunities to expand efforts to improve preventive women's health care beyond the current strategies for LARC.

Factor Contributing to Success

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

- The Executive Office of Early Learning's Action Strategy Planning process which is supported by the Governor's Office in conjunction with substantial funding commitment from the Hawaii Community Foundation/Omidyar Foundation (the former established by the founder of Ebay)
- the 2013 National Governor's Association (NGA) Learning Network to improve Birth Outcomes, and
- Hawaii participation in the national Infant Mortality Collaborative Improvement and Innovation Network (CoIIN).

In addition, Title V has utilized resources of key partners to provide leadership, staffing and funding to sustain these collaborative efforts over the past three years. These resources were crucial since the Maternal and Child Health Branch staffing and management have been hampered by significant turnover, loss of staffing due, and funding cuts over the past 5 years.
Examples of resources include funding for the collaborative work has been provided by the Department of Health (DOH), Centers for Disease Control Preventive Health and Health Services Block Grant (PHHSBG) to hire a facilitator/coordinator for the HMIHC and CoIIN projects. Administered by the DOH Office of Planning, Policy and Program Development, the CDC grant funding has been essential to sustain the momentum and work of the Collaborative. Additional PHHSBG funding will be used to support LARC activities including workforce training.
The March of Dimes Hawaii Chapter has provided leadership and assistance to support ongoing communication for the Collaborative members to assure engagement and recruitment of new members and provided funding and office space for meetings

Challenges, Barriers

Some of the challenges to implementing LARC activities include:

- Establishing, coordinating and implementing linkages to ensure timely data for project benchmarks,
- Assuring all applicable providers provided the Hawaii LARC Reimbursement Guide with adequate information and training to utilize the guide effectively, and

- Potential provider barriers to LARC such as insurance coverage of device and on-site proctor insurance training for inexperienced providers.

Completing 5-Year Action Plan Activities

Family Health Services Division through its Maternal and Child Health Branch will continue to participate in the HMIHC, CoIIN and project activities discussed above. This will include participation in the Boston CoIIN In Person Learning Session 2, July 27-28, 2015. This engagement will support assessing progress to date, identifying opportunities for continued improvement in reducing infant mortality, promoting cross-state collaboration and identifying new approaches, and improving use of data and forming plans to integrate stakeholders to move forward practice improvement. The HMIHC will continue to hold its monthly meetings including pre conception and interconception work group meetings to address this priority.

Women/Maternal Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	65	65	65	65	65

For the Women's/Maternal population domain, Hawaii is reporting on the national and state performance measures which address the following issues:

- NPM 15: Smoking during Pregnancy
- NPM 18: Prenatal care
- SPM 01: Unintended pregnancy
- SPM 02: Alcohol Use during Pregnancy

Data Issues

Three of the four measures in this population domain rely on data from the Hawaii Pregnancy Risk Assessment Monitoring System (PRAMS). Due to changes at CDC and personnel changes in Hawaii PRAMS, PRAMS data from 2011 is the latest available data for this report. The data for 2012 is expected later in summer of 2015. The Hawaii 2013 data was submitted to CDC and is in the process of being weighted. Hawaii's 2014 data collection is completed and arrangements are being made for data entry by approved CDC contactors. Data collection for PRAMS 2015 is ongoing.

Hawaii implemented the 2003 revision of the birth certificate in 2014 and due to changes in specific data collection of some items, some indicators are not comparable across the transition. For example, prenatal care entry (NPM 18) is not comparable, but high risk deliveries at tertiary care centers (NPM 17) is comparable across. The way information on prenatal care entry data collection has changed, but the hospital and birth weight data collection methodology did not.

NPM 15: Percentage of women who smoke in the last three months of pregnancy.

Smoking is the single largest known preventable risk factor for poor pregnancy outcomes. The 2011 data (latest available) indicates 5.0% of pregnant women reported smoking during the last trimester of pregnancy. The State objective of 7% was met; the Healthy People 2020 Objective of 1.4% was not met.

According to Hawaii PRAMS data from 2009-11, of the women who smoked prior to pregnancy, 35.6% smoked during the last trimester of pregnancy and 55.5% reported smoking 2-9 months postpartum.

Title V administers the Perinatal Support Services (PSS) program with contract providers throughout the State.

Services include outreach, risk assessments/screenings, health education, and case management for high-risk pregnant and postpartum women. PSS providers screen smoking behaviors and refer for cessation counseling. In October 2013, a PSS request for proposal was issued. Contracts began with seven providers on July 1, 2014 with services to continue through June 30, 2016. The scope of work will continue to include the PSS service delivery components.

The WIC program screens pregnant women and mothers and makes referrals to the statewide Hawaii Tobacco Quitline and community health centers for smoking cessation classes and interventions.

Perinatal services continue to be provided by the DOH Public Health Nursing staff in Hawaii County through the Hawaii Island Perinatal Program (HIPP). The program includes screening for smoking and referrals for smoking cessation. PSS and HIPP programs continue to promote early prenatal care (PNC) for high-risk women.

MCHB contracts with the Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii to provide system building support for the improvement of statewide perinatal services. HMHB coordinates the statewide Perinatal Advocacy Network (PAN) meetings and works with MCHB to convene quarterly perinatal provider meetings. HMHB also provides health messaging through the pregnancy resource, referral, information phone line, website and "text4baby" program.

A revised PRAMS survey will continue to assess smoking behaviors before, during, and after pregnancy. The PRAMS program has an ongoing partnership with the Tobacco Prevention and Education Program to collect and monitor this data for the state smoking prevention plan.

NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Provisional data for 2014 indicates 81.7% of pregnant women received first trimester PNC. The state objective of 88% was not met; however, the Healthy People 2020 objective of 77.9% was met. Due to the birth certificate revision 2014 data is not comparable to previous years; however, rates prior to 2014 have remained relatively stable for the past 8 years.

Title V administers the Perinatal Support Services (PSS) Program with contract providers throughout the State. PSS providers conduct outreach, risk assessment/screenings, health education, and case management to high-risk pregnant women, up to 6 months post-partum. Access to early PNC is supported through community outreach, education, and by assisting uninsured pregnant women with Medicaid applications.

In October 2013, a PSS request for proposals was issued. Contracts began July 1, 2014 with services to continue through June 30, 2016. The scope of work will continue to include the PSS service delivery components.

Perinatal services continue to be provided through DOH Public Health Nursing staff in Hawaii County through the Hawaii Island Perinatal Program (HIPP). PSS and HIPP programs continue to promote early PNC for high risk women and healthy behaviors.

Four Local Area Consortia (LAC) continue to meet to improve the Hawaii County perinatal health care system. The LACs have continued to identify and implement actions to address broader system issues such as increasing access to care.

HMHB Coalition of Hawaii provides system building support to improve statewide perinatal services. For this HMHB conducts needs assessments in coordination with the Title V MCH Branch (MCHB) to identify statewide issues/concerns affecting the perinatal population. This included in July 2014 an Assessment of Parents' and Providers' Knowledge and Use of Postpartum Depression Support Resources in Hawaii. Bi-annual Statewide Perinatal Provider Advocacy Network (PAN) meetings are held to facilitate discussions on legislation, perinatal service issues, and to share strategies to assure early and ongoing PNC by improving outreach and case management. HMHB works with MCHB to plan the quarterly PSS provider meetings and sponsor workforce trainings. HMHB also manages the pregnancy referral and information phone line, "text4baby," and website that include information on PNC.

In May 2013, the DOH was selected to join the National Governor's Association (NGA) Learning Network to Improve Birth Outcomes. The Learning Network assisted states in developing, implementing and aligning key policies and initiatives to improve birth outcomes. This effort is assisted to fulfil the DOH commitment to reduce infant mortality

and improve birth outcomes. Approximately 60 private and public stakeholders attended the NGA In-State Planning Session on July 17, 2013. Perinatal and women's health data was presented and reviewed to assess needs and identify issues. Participants emphasized the need to have a life course approach; a collaborative to address improvement of birth outcomes including a clinical component; access to relevant data for ongoing assessment on improvement of birth outcomes; and that discussions, development of strategies, and approaches continue.
A Hawaii Team including DOH, March of Dimes Hawaii Chapter, and Health Care Association of Hawaii attended a Washington, DC conference to share our efforts and hear from national experts of their challenges and successes. As a result of the planning session and conference, the Hawaii Maternal and Infant Health Collaborative (HMIHC) was formed. A planning document was developed, "The First 1,000 Days", which aimed at achieving an 8% reduction in preterm births and 4% reduction in informant mortality by 2018. Three work groups were formed:

- preconception and interconception care;
- pregnancy, care during pregnancy and delivery, and
- infant health and safety.

The groups identified strategies and tactics to decrease preterm births for each perinatal period. To date over 80 members across Hawaii have been involved in the HIMHC and include physicians and clinicians, public health planners and providers, insurance providers and health care administrators.
In July 2014, the DOH along with public private partners participated in the national Collaborative Improvement and Innovation Network Summit (CoIIN) to Reduce Infant Mortality in WA, D.C., these efforts coordinated and support the work of the HIMHC. As part of the HIMHC there is a core leadership team which meets monthly to develop and revise the HMIHC plan, ensure stakeholder engagement, and address barriers to implementation. The HIMHC also distributes a quarterly newsletter to inform collaborative stakeholders on activities and progress occurring and support ongoing engagement in these efforts.
The Hawaii PRAMS survey includes questions on prenatal care.

SPM 01: Percent of pregnancies (live births, fetal deaths, abortions) that are unintended.

This measure reflects the state Title V priority to reduce the rate of unintended pregnancy (UP) in Hawaii. The percent of UP increased slightly from 51.6% in 2011 to 52.0 % in 2012, although the data is provisional. The state objective was not met, nor was the Healthy People 2020 Objective of 46%. Because Hawaii uses PRAMS data to this measure no new data is available at this time.
In 2012, 70,970 women in Hawaii were in need of publicly supported contraceptive services and supplies. This includes 17,100 women less than 20 years of age. Many women who do not have health insurance cannot afford contraceptive services. When family planning services are not used, women have an increased risk for an unintended pregnancy. Nearly half of women with UP were using contraception. The use of effective contraceptive method (CM) to prevent UP is well known but education to clients and providers to increase awareness and access to accurate information, client-centered counseling approach that includes discussing the most effective contraceptive methods first and providing these methods at reduced or not cost to the clients are barriers to its acceptance and utilization.
Family planning (FP) services administered by the Title V MCH Branch (MCHB) Reproductive Health Services Unit are funded primarily by the federal Title X Family Planning Services. FP services are available in 38 clinic sites in 10 community health centers, 1 college and 1 university health center, 1 hospital, and 1 community-based non-profit organization located on 6 of the major islands. Target populations are the uninsured and underinsured, males, adolescents, homeless and at-risk youths, immigrants, persons with limited English proficiency, persons exposed to or experiencing violence, clients recently released from incarceration and others experiencing situations that impact their ability to access health related services. Providers offer outreach, clinical education, and referral services, and translation services. FP education materials are culturally tailored to meet the needs of varied racial/ethnic, geographic, and disparate groups. Title V programs and other departmental programs (i.e. STD/HIV Prevention Program), and community partners refer clients to FP services.

There were 37,129 clinic visits by 18,999 clients in FY 2014. Over two-thirds of clients received services through community health centers (CHC), 84% had incomes less than 100% of the Federal Poverty Level, and 30% uninsured. The proportion of FP clients who have a positive pregnancy test and stated they are avoiding pregnancy declined from 63% in FY 2013 to 50.3% in FY14. Our data indicates over 70% of the FP clients state they are not seeking pregnancy and leave with a chosen method. Counseling and developing a reproductive life plan and preconception planning, as appropriate are integral components of the FP services. Long acting reversible contraceptive (LARC) use rates in teens are higher among Title X clients than the national average. Hawaii ranks 5th highest in the nation in LARC use for 15-19 years old and 4th for 18-19 years old.
Population-based services provided through 11 Title X FP community health educators (HE) statewide emphasized discussing a reproductive life plan with all FP clients and providing preconception health services as part of FP, as appropriate. Activities to increase awareness of how to access FP services include distribution of educational materials, health fairs, and mass media. There were 46,579 adolescent and 14,579 male educational contacts made in FY 2014. In addition, 49,515 direct contacts and 372,048 indirect contacts were served,
The Title X funded digital video disk presentation on FP and CM developed and translated by Kalihi Palama Health Center in Marshallese, Chuukese, Vietnamese and Mandarin languages has been distributed for clients to take home and have follow-up discussions with partners and significant others to assist with the decision process on contraceptive use.
In May 2013, the DOH was selected to join the National Governor's Association (NGA) Learning Network (LN) to Improve Birth Outcomes. Hawaii is involved in the CoIIN to reduce infant morbidity. The Hawaii Maternal and Infant Health Collaborative (HMHIC) was formed as part of this effort with a workgroup focused on improving preconception and interconception health and care. The workgroup released a white paper assessing the potential barriers to LARC including access following delivery and any related Medicaid coverage barriers. More details are provided in NPM 15 and 18 narratives regarding the CoIIN/HMHIC efforts.
Two FP health educators provided comprehensive sex education at the Boys and Girls Club of Hawaii's (BGCH) Nanakuli and Spalding Clubhouses'. This is the 2nd program year of the Abstinence Education Grant Program (AEGP). The promising Skilled Mastery and Resistance Training (SMART) Moves curriculum, is a product of the Boys and Girls Club of Hawaii and is the abstinence curriculum used to educate 231 participants aged 10-16 in positive youth development and teen pregnancy prevention.

SPM 02: Percent of women who report use of alcohol during pregnancy.

This measure reflects the State priority to reduce prenatal alcohol use. The priority was selected based on research demonstrating how alcohol use during pregnancy has many negative effects on the developing fetus. The 2011 indicator is 6.9% (the latest available data); the annual objective was nearly met. The rate has stayed stable over the past 5 years. The Healthy People 2020 objective of 1.7% was not met.
The Title V MCH Branch administers the Perinatal Support Services (PSS) Program with contracted providers throughout the State. The PSS providers conduct outreach, risk assessment/screenings, health education, and case management to high-risk pregnant women, up to 6 months post-partum. Providers screen clients for prenatal and post-partum alcohol use, and provides brief interventions and referrals for treatment.
The federally funded Healthy Start Big Island Perinatal Health Disparities program (BIPHDP) provides perinatal and postpartum support services to high-risk pregnant women. The program targets women of Native Hawaiian, Other Pacific Islander, Filipino, and Hispanic ancestry as well as teens. The program screens clients for prenatal and post-partum alcohol use, and provides brief interventions and referrals for treatment. The BIDHP provider contract ended in March. Services continue to be provided by DOH Public Health Nursing (PHN) and Title V staff. The service delivery component of this program under PHN was renamed to Hawaii Island Perinatal Program (HIPP). PSS and HIPP programs continue to support access to early prenatal care and promote healthy behaviors for high risk women.
The BIDHP grant helped support four Local Area Consortia (LAC) that work to improve the Hawaii County perinatal health care system. The LACs have continued to identify and implement actions to address broader system issues.

The WIC program at the initial client visit uses a health questionnaire to screen for alcohol use during pregnancy and refers when appropriate.
The Children's Research Triangle (CRT) continues to expand its perinatal screening and intervention for substance use during pregnancy to Federally Qualified Health Centers (FHQC) after starting the program on Hawaii Island. CRT also conducted a training with pediatricians, OB/GYN's, and hospital nurses on Maui on the CRT 4 P's Plus screening tool. CRT continues to meet with partners, including Title V, to build a system of services to prevent, screen, and treat substance use/abuse, including alcohol, among women.
Title V continued to provide staffing for the Fetal Alcohol Spectrum Disorders (FASD) Task Force (TF) comprised of private/public partners. Staff supported the TF in partnership with the Hawaii MCH **L**eadership **E**ducation in **N**eurodevelopmental and Related **D**isabilities (LEND) program to develop a legislative bill that would establish an Interagency Council to promote awareness building, screening and treatment for individuals with a FASD. The LEND program prepares health professionals for leadership roles to improve support and services for children with special health needs and their family members. Unfortunately, the bill was not passed.
A number of different awareness building and education efforts were conducted across the islands. As part of September FASD Awareness Month, three of the four county mayors conducted proclamation signings. The warning signs developed with TF partners and funded by the March of Dimes and the DOH CDC Preventive Health Services Block Grant were again placed on all of Oahu's public buses. The Maui county bus system agreed to retain the warning signs from the previous year. National training resources were returned to the islands covering mental health treatment planning and strategy development and diagnosing FASD, and developing a strategic plan for FASD.
The TF Clinical Committee addressed screening and testing for neuro-cognitive deficits; currently used screening and assessments tools, the need to increase the awareness, diagnostic capacity of providers in the community; and expanding treatment/referral resources.
The HMHB Coalition of Hawaii provides system building support to improve statewide perinatal services. HMHB coordinates the statewide Perinatal Advocacy Network (PAN) meetings and quarterly perinatal provider meetings where FASD prevention information is shared. HMHB also provides health messaging through an information phone line, website and "Text4baby" program that includes information on abstaining from alcohol use during pregnancy. Through a federal Healthy Care grant, HMHB launched a marketing campaign to publicize resources to support healthy pregnancies and early newborn care.

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Reduce the rate of infant mortality	By July 2020, increase the percent of of infants who are ever breastfed to 94% (Baseline: 2011 NIS data 89.5%) By July 2020,	• Strengthen programs that provide mother-to-mother support and peer counseling. • Use community-based	Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months		

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	increase the percent of infants breastfed exclusively through 6 months to 28% (Baseline: 2011 NIS data 26.4%)	organizations to promote and support breastfeeding.	births			
Reduce the rate of infant mortality	By July 2020, increase the percent of infants placed to sleep on their backs to 82% (Baseline: 2011 PRAMS data 78.1%)	• Review all birthing hospital policies and training needs • Increase infant safe sleep environment knowledge for caregivers • Safe sleep behavior is understood and championed by trusted individuals. • Collect information on co-sleeping beliefs and behaviors among diverse culture in Hawaii.	Infant mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	Percent of infants placed to sleep on their backs		

Perinatal/Infant Health

Perinatal/Infant Health - Plan for the Application Year

Preliminary 5-Year Plan: Breastfeeding

The 5-year needs assessment affirmed the importance of breastfeeding as a priority issue. Founded in 2013, the Hawaii Maternal and Infant Health Collaborative is a public-private partnership committed to work on the Executive Office of Early Learning's Action Strategy #1 Improving Birth Outcomes and Reducing Infant Mortality.
Priority: Reduce the rate of infant mortality by improving breastfeeding rates.
New state priorities focus on improving breastfeeding rates of infants ever breastfed and breastfed exclusively through 6 months, based on the Title V National Performance Measures.
Objectives:
The preliminary 5-year plan objectives were developed using the National Immunization Survey (NIS) data as a baseline and projecting a 5 percent improvement for infants ever breastfed and 6 percent improvement for infants exclusively breastfed at 6 months over the next five years.

- 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%)

National Performance Measures:

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

5-Year Strategies:

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

Strategy Development
The strategies were extracted from the Actions for Communities section of the 2011 Surgeon General's Call to Action to Support Breastfeeding. To assure regular feedback/input, breastfeeding stakeholders are routinely informed about the initiative through reports at meetings, web/conference calls, email updates, and conferences.
Plans for Application Year Federal Fiscal Year 2016 (10/01/15-09/30/16):

- Train home visitors on helping mothers overcome common breastfeeding challenges.
- Refer all pregnant WIC moms to Healthy Mothers Healthy Babies Text4Baby service.
- Increase capacity at birthing facilities by offering a "Baby Behavior Train the Trainer" session.
- Continue participation of WIC Breastfeeding Coordinator as a coalition board member.

Factors Contributing to Success
Title V programs continue supporting high-risk pregnant women through the Hawaii Island Perinatal Program and WIC. Home visitors and others working with breastfeeding mothers received training to build support capacity in partnership with WIC and the Hawaii and Maui District Health Offices.
The WIC Breastfeeding Coordinator participated as a Breastfeeding Hawaii board member (the State Breastfeeding Coalition) and attended monthly meetings.
In August 2014 WIC co-sponsored a World Breastfeeding Week event with Castle Medical Center and Breastfeeding Hawaii. The event was marketed to pregnant women and featured a variety of sessions such as: Tips for Successful Breastfeeding; Food Myths of Hapai & Breastfeeding Moms; Family & Community Roles in Caring for Baby; Getting the Support You Need; How to Choose a Pediatrician and How Healthy Mothers Healthy Babies Can Help Your Family. Approximately 50 attendees attended the event.

The Affordable Care Act requires breast pump coverage through medical plans which can assist mothers with exclusive breastmilk feeding, especially as new mothers return to work or school.

Challenges, Barriers

While Hawaii has many dedicated breastfeeding advocates and partners, efforts to develop strategies and sustain

their implementation has been difficult due to the lack of a Statewide Breastfeeding Coordinator to serve all families.

Despite Hawaii's excellent breastfeeding initiation rate, the CDC's Maternity Practices in Infant Nutrition and Care report shows that birthing facilities in Hawaii still have opportunities for improvement. Areas for improvement include appropriate use of breastfeeding supplements, inclusion of model breastfeeding policy elements, provision of hospital discharge planning support and adequate assessment of staff competency. Since the benefits of breastfeeding are dose-related, duration and degree of exclusivity need to be reviewed as well.

Completing 5-Year Action Plan Activities

FHSD will continue to work on the current administrative and project activities discussed above. An update on progress will be provided in next year's Title V report and needed adjustments made to the preliminary 5-Year Plan. Performance measures will be identified for evidence-based practices based upon guidance provided by AMCHP and the federal MCH Bureau.

Preliminary 5-Year Plan: Safe Sleep

The 5-year needs assessment confirmed the importance of providing safe sleep education and training to parents and childcare providers as a priority issue. Founded in 2013, the Hawaii Maternal and Infant Health Collaborative, is a public private partnership committed to Improving Birth Outcomes and Reducing Infant Mortality. The Collaborative was developed in partnership with the Executive Office of Early Learning's Action Strategy with help from the DOH and National Governor's Association. The National Institute for Children's Health Quality provides technical assistance to the Collaborative through our participation in the national CoIIN Initiative. The Collaborative has completed a strategic plan and accompanying Logic Model, The First 1,000 Days, aimed at achieving the outcomes of 8% reduction in preterm births and 4% reduction in infant mortality by 2018. The Collaborative has identified two priority strategies to achieve the objective of decreasing infant mortality in the first year of life, they are 1) to foster safe sleep practices for all who care for infants and 2) to provide professional development and training opportunities for caregivers of infants.

Priority: Promote Safe Sleep practices

The state priority is based on the Title V block grant guidance National Performance Measures for safe sleep practices which focuses on infant health. The focus on improving safe sleep practices is a new priority for Hawaii.

Objectives:

- By July 2020, increase the percent of infants placed to sleep on their backs to 82% (Baseline: 2011 PRAMS data 78.1%)
  The preliminary 5-year plan objectives were developed using the Pregnancy Risk Assessment Monitoring System data as a baseline and projecting a 4 percent improvement over the next five years.

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

5-Year Strategies:

- Review all birthing hospital policies and training needs
- Increase infant safe sleep environment knowledge for caregivers
- Safe sleep behavior is understood and championed by trusted individuals.
- Collect information on co-sleeping beliefs and behaviors among diverse culture in Hawaii.

Strategy Development

The five strategies were extracted from the Safe Sleep Team's national CoIIN Initiative's Planning Worksheet. To assure regular feedback/input, safe sleep stakeholders are routinely informed about the initiative through reports at meetings, web/conference calls, email updates, conferences, and newsletters.

Plans for Application Year Federal Fiscal Year 2016 (10/1/15-9/30/16):

- Develop a survey for childcare providers to determine their preferred method of receiving training.
- Develop focus group questions for providers working with parents to gain an understanding of the challenges related to providing safe sleep education to parents.
- Develop questions for parents to better understand parental reactions and responses to different safe sleep messages.
- Provide feedback towards the development of administrative rules and the development of a safe sleep policy template.
- Integrate safe sleep education into WIC services.
- Continue new and ongoing safe sleep training of health professionals working with new parents.

The Safe Sleep Hawaii Committee was formed in 2002 by Dana Fong, a safe sleep champion who continues to advocate for the ongoing training and education increasing awareness of safe sleep practices. In 2015, Safe Sleep Hawaii and new safe sleep partners came together as the national CoIIN Initiative Hawaii Safe Sleep Team. Through CoIIN, the collaborative effort combines partners from hospitals, early child care partners, home visitors, parenting educators, nurses, physicians, parent advocates, and public and private agencies. To help inform the efforts the Hawaii Safe Sleep Team is first working to reinstitute the state's Child Death Review to provide surveillance data.

Factors Contributing to Success

Safe Sleep Hawaii has promoted each October as Safe Sleep Awareness Month and has secured legislative and gubernatorial proclamations and press releases to raise awareness of the issue. A Core Committee of dedicated Safe Sleep Hawaii members worked to support the establishment of safe sleep policies in all birthing hospitals. In 2013, Safe Sleep Hawaii worked to introduce and successfully pass legislation that required safe sleep practices to be addressed in childcare facilities. The legislature has also provided grant funding to support the Cribs for Kids program which provides education and free cribs to new parents with limited resources. Sleep Hawaii and other Core Committee members also work and respond between the monthly national CoIIN webinars/calls.

Challenges, Barriers

While Hawaii has many dedicated safe sleep advocates and partners, efforts to develop a universally adopted training on safe sleep practices has been difficult due to the established, but understated practice of co-sleeping amongst local families. The general acceptance of bed sharing has anecdotally been attributed to the state's ethnic/cultural diversity and economic constraints related to the State's high cost of housing which contributes to the sharing of small dwellings and/or multi-family living arrangements. Current training and policies promote the 2011 expanded recommendations set by the American Academy of Pediatrics (AAP) that states that babies should share a room with their parents, but not share their beds. However, parents continue to choose to sleep with their babies and much discussion by safe sleep advocates has focused on shifting to harm reduction training in order to help in-home service providers to engage parents in making decisions on how they can create as safe of an environment as possible within the context of their living situation and values. Funding cuts to the Child Death Review program has led to the loss of data that could inform which risk factors are associated with sleep related infant deaths.

Completing 5-Year Action Plan Activities

FHSD will continue to work on the current administrative and project activities discussed above. An update on progress will be provided in next year's Title V report. Any needed changes to the preliminary 5-Year Plan will be made. Based upon guidance provided by AMCHP and the federal MCH Bureau, performance measures will be identified for evidence based practices.

Perinatal/Infant Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	94.0	94.0	94.0	94.0	94.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	28.0	28.0	28.0	28.0	28.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	82	82	82	82	82

For the Perinatal/Infant population domain, Hawaii is reporting on the national and state performance measures which address the following issues:

- NPM 1: Newborn Screening
- NPM 11: Breastfeeding
- NPM 12: Newborn hearing screening
- NPM 17: High risk deliveries at tertiary care centers

NPM 1: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

In fiscal year (FY) 2014, 100% of infants who screened positive received timely follow-up to definitive diagnosis and clinical management for conditions mandated by the State sponsored newborn screening program.

The Hawaii Newborn Metabolic Screening Program (NBMSP) is administered by the Children with Special Health Needs Branch (CSHNB). NBMSP has statewide responsibilities for assuring that all infants born in the state are tested for 32 disorders and another 25 secondary conditions found in the course of screening for the core conditions. This meets the national newborn screening recommendations from the American College of Medical Genetics and Genomics and the March of Dimes.

NBMSP is self-sustaining through a $55 fee assessed for each screening specimen collection kit. Hospitals purchase the collection kits and the fees are deposited in a state newborn metabolic screening special fund.

A Critical Congenital Heart Disease (CCHD) bill, that would have required hospitals to screen each newborn for CCHD with the use of pulse oximetry and to report the data and information to DOH, was introduced but did not pass this legislative session. However, NBMSP assisted hospitals in the implementation of and written policies for routine

pulse oximetry for all newborns. To date, all birthing hospitals statewide have included routine pulse oximetry as part of their newborn care.

The Statewide NBMSP Advisory Committee met in September for updates including increasing the fee from $55 to $85 and to discuss adding Severe Combined Immunodeficiency Disease (SCID) to Hawaii's newborn screening panel. The members were in agreement that SCID should be added to the panel. Plans are to begin SCID screening early 2015 as time is needed to develop a draft protocol for follow up, explore the resources available on Oahu, the neighbor islands, and the mainland if a newborn screens positive; and provide technical assistance to stakeholders. The increase in fees is necessary for the addition of SCID screening and the increase in general administrative costs. The fee has not been increased since 2006.

NBMSP maintained oversight of the newborn metabolic screening system: obtaining blood specimens at hospitals, specimen transport, central laboratory testing, physician notification, and tracking. NBMSP staff tracked all infants who were diagnosed with metabolic and other disorders, had abnormal and unsatisfactory screening results, transferred to another facility, or were not screened. For infants who were confirmed with disorders, NBMSP identified the medical home, linked the medical home with the metabolic consultants, and followed-up with the medical home to ensure timely treatment. Follow-up was also provided for infants who did not receive newborn screening as identified by "Specimen Not Obtained" forms and Hospital Monthly Newborn Screening Reports from birthing facilities.

The midwives' reporting accounted for 275 out of approximately 329 home births. To assure access to newborn screening, NBMSP provided newborn screening specimen collection kits to midwives and naturopaths with payment dependent on parents' ability to pay. The NBMSP coordinator along with the Newborn Hearing Screening Program (NBHSP) coordinator met with midwives on Maui to discuss the changes in both programs and ways to increase screening rates. Plans for the coordinators are to present to the annual meeting of the Midwives Alliance of Hawaii in December 2014.

NBMSP continued to provide informational packets with newborn metabolic screening and hearing screening information to midwives, as well as to the District Health Offices on each island and the Vital Statistics office on Oahu.

NBMSP continued to contract a Hemoglobinopathy Clinic and DNA mutation testing for alpha thalassemia testing to improve genetic counseling services to families. This analysis is needed for accurate alpha gene mutation information.

NBMSP along with the Genetics Program continued to participate in HRSA's multi-state Western States Genetic Services Collaborative to coordinate and improve access to genetic services for children with genetic disorders.

NBMSP funds Hawaii Community Genetics to provide clinic services for infants and their families with metabolic disorders and Hemoglobinopathies. CSHNB contributes services of genetic counselors, metabolic nutritionist, and a NBMSP coordinator or follow-up nurse.

NPM 11: The percent of mothers who breastfeed their infants at 6 months of age 12.

The provisional 2014 data indicates that in 2011, 61.5% of Hawaii mothers were breastfeeding their infants at 6 months, a decrease from fical year (FY)2013 but significantly higher than previous years. The 2014 indicator met the HP 2020 objective of at least 61% of women breastfeeding their infants at 6 months of age and Hawaii greatly surpassed the national rate of 49.4%

Title V administers the Perinatal Support Services (PSS) program with contract providers throughout the State. Services include outreach, risk assessments/screenings, health education, and case management for high-risk pregnant and postpartum women. PSS providers provide information and encourage new mothers to breastfeed.

The Title V administered Big Island Perinatal Health Disparities Program (BIPHDP) provided perinatal support services (PSS) to high-risk pregnant women on the island of Hawaii. In 2013, services moved to the DOH Public Health Nursing and the service delivery components of this program were renamed Hawaii Island Perinatal Program (HIPP). Services are provided for two years during the interconception period and include breastfeeding promotion and education prenatally and postpartum. Their target population included women of Hawaiian, Pacific Islander,

Hispanic, and Filipino ancestry and adolescents. The impact of these efforts resulted in an average breastfeeding duration of seven weeks for women who were enrolled prenatally and had a child at least six months old at the time of data collection.

In partnership with WIC and the Hilo and Maui District Health Offices, members of the Hawaii Home Visiting Network and others working with breastfeeding mothers received training to support capacity building in community based programs. The trainings were held on May 22nd and 23rd in Hilo and August 25th and 26th in Maui and were conducted by three WIC State Agency staff – Melanie Murakami, Belinda Reyes and Lorilyn Salamanca.

Title V administers the Hawaii Home Visiting Network which provides information and support on breastfeeding to participants.

The WIC Breastfeeding Coordinator participated as a board member to the State Breastfeeding Coalition, Breastfeeding Hawaii, and attended monthly meetings. Breastfeeding Hawaii is a federally recognized 501(c) (3) organization with a mission to promote, protect, and support breastfeeding within the State of Hawaii through collaboration and organization of community efforts, outreach, legislation, policy change, education, and advocacy. The coalition's vision is that breastfeeding be seen by Hawaii's community and families as the normal natural way to nourish and nurture infants. The Hawaii WIC Program's State Agency Breastfeeding Coordinator serves as a board member to help recommend and implement breastfeeding promotion efforts.

WIC co-sponsored a World Breastfeeding Week (WBW) event in August 2014 event with Castle Medical Center and Breastfeeding Hawaii. The event was marketed to pregnant women and featured a variety of sessions such as: Tips for Successful Breastfeeding; Food Myths of Hapai & Breastfeeding Moms; Family & Community Roles in Caring for Baby; Getting the Support You Need; How to Choose a Pediatrician; and How Healthy Mothers Healthy Babies Can Help Your Family. Approximately 50 attendees attended the event.

NPM 12: Percentage of newborns who have been screened for hearing before hospital discharge.

The 2013 data showed that 99.2% of newborns were screened for hearing before hospital discharge. The 2014 preliminary data showed that 99% were screened. The objective of 99% was met. The 2014 rate will likely increase since not all hospitals have reported at the time of this report.

Newborn Hearing Screening Program (NHSP) began in 1990 through a law mandating that DOH establish a statewide program for screening of infants and children age 0-3 years for hearing loss. Screening began in two hospitals in 1992 and was provided in all birthing facilities by 1999. The NHSP law was amended in 2001 to mandate screening of all newborns for hearing loss and reporting of screening results to the DOH. Hearing screening is now available to families statewide, regardless of birth location. All hospitals have both otoacoustic emissions (OAE) and automated auditory brainstem response (AABR) screening capability and backup equipment. By 2013, all except one birthing hospitals implemented the two stage (OAE and AABR) hearing screening.

Funding from the MCH Bureau for the Baby Hearing Evaluation and Access to Resources and Services (Baby HEARS)-Hawaii project has supported the CSHNB/NHSP efforts to improve newborn hearing screening and follow-up in Hawaii since 2000.

NHSP continues to work closely with hospitals and medical home providers. NHSP reconciles state data monthly against hospital delivery logs and tracks follow-up needs. All hospitals which submitted screening data to the HI*TRACK data system use the web-based system. The web-based system provides real time data to facilitate timely services and improved follow-up.

Contracts with four community providers to conduct hearing screening for home births continued in 2014. The NHSP loaned the screening equipment, arranged for onsite training, and provided ongoing technical support to the contractors. Screening rates for homebirths increased from 15% to 49% in 2013.

The NHSP/ Early Hearing Detection and Intervention (EHDI) Advisory Committee has 19 members. The committee met four times in 2014. The committee members received training on the quality improvement methodology (Plan-Do-Study-Act) in 2014 and agreed to serve as the Quality Improvement Team to oversee the Baby HEARS grant quality improvement activities.

Two NHSP brochures were finalized and printed. The "Hawaii Newborn Hearing Screening - information for New Parents" brochure is distributed to new parents before their babies receive hearing screening. The "Can Your Baby

Hear?" brochure is about hearing development and is distributed to parents after their babies completed hearing screening.
To strengthen parent support and participation, NHSP continued to collaborate with the Deaf/Hard of Hearing (D/HH) Specialist and the Hands & Voices (H&V)-Hawaii Chapter and offered workshops and other activities for families with D/HH children.
A work group was established to revise the resource guide, "Sound Step", for parents of deaf and hard of hearing children. The revised draft was distributed to parents for their review and input and is awaiting finalization and publication.
NHSP staff met with midwives to discuss barriers for homebirth screening. As a result, a work group was established to develop talking points for the midwives to be used as a tool to discuss hearing screening with parents.
NHSP and the Newborn Metabolic Screening Program (NBMSP) coordinate on quality assurance efforts and provide brochures/letters to homebirth families through Birth Registrars and the district health offices.
NHSP, with the support of the CSHNB Research Statistician, continues to monitor the percentage of children who are lost to follow-up/documentation at all stages and to document progress.

NPM 17: Percent of very low birth weight (VLBW) infants delivered at facilities for high-risk deliveries and neonates.

Provisional data for 2014 report 90.5 % of VLBW infants were delivered at facilities for high-risk deliveries and neonates. The objective was not met but exceeded the Healthy People 2020 objective of 83.7%. The rate increased slightly over 2013 (89.7%).
Title V programs work to reduce preterm births and VLBW infants targeting services to high-risk pregnant women. Programs include the Perinatal Support Services (PSS) with contracted providers throughout the state that conduct outreach, risk assessments, health education, and case management to high-risk pregnant women up to 6 months post-partum.
Title V supports infrastructure building services through a contract with Healthy Mothers Healthly Babies Coalition of Hawaii (HMHB) to enhance the statewide perinatal system of care through assessment, advocacy, pregnancy resource information, and perinatal provider training.
In May 2013, the DOH was selected to join the National Governor's Association (NGA) Learning Network to Improve Birth Outcomes. The learning network technical assistance led to the establishment of a Hawaii Maternal Infant Health Collaborative (HIMHC) to identify and implement several strategic activities to improve birth outcomes. More details are available in the narrative for in NPM 18 under the Women's/Maternal domain narrative report.
In July 2014, the DOH along with public private partners participated in the national Collaborative Improvement and Innovation Network Summit (CoIIN) to Reduce Infant Mortality in Washington, D.C., these efforts are part of those of the HIMHC. As part of the HIMHC there is a core leadership team which meets monthly to develop and revise the HMIHC plan, ensure stakeholder engagement, and address barriers to implementation. The HIMHC also distributes a quarterly newsletter to inform collaborative stakeholders on activities, monitoring progress, and support ongoing engagement in these efforts.

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Improve the percentage of	By July 2020, increase the	• Training & Technical	Percent of children meeting the criteria	Percent of children, ages		

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
children screened early and continuously age 0-5 years for developmental delay	percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool to 41% (Baseline: 2011-2012 NSCH data 38.9%)	Assistance. Develop infrastructure for on-going training, technical assistance, and support for practitioners conducting developmental screening activities. • Policy & Advocacy. Develop protocols, guidelines and standardized referral processes and communication system on developmental screening. • Data & Evaluation. Develop data system to track and monitor screening, referral, utilization system. • Family Engagement. Develop collateral	developed for school readiness (DEVELOPMENTAL) Percent of children in excellent or very good health	10 through 71 months, receiving a developmental screening using a parent-completed screening tool		

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		material needed to support understanding and importance of developmental screening. • Service System. Develop website to house materials, information, and resources on developmental screening.				
Reduce the rate of child abuse and neglect with special attention on ages 0-5 years.	By July 2020, reduce the rate of confirmed child abuse and neglect reports per 1,000 for children aged 0-5 years to 5.9% (Baseline: Center on the Family 2013 6.2)	• Raise awareness about the importance of safe and nurturing relationships to prevent child abuse/neglect. • Improve evaluation capacity of Title V Family Support and Violence Prevention Section programs to assure improved	Child Mortality rate, ages 1 through 9 per 100,000 Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000	Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19		

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		outcomes. • Improve collaboration and integration between programs addressing child wellness and family strengthening.				

Child Health

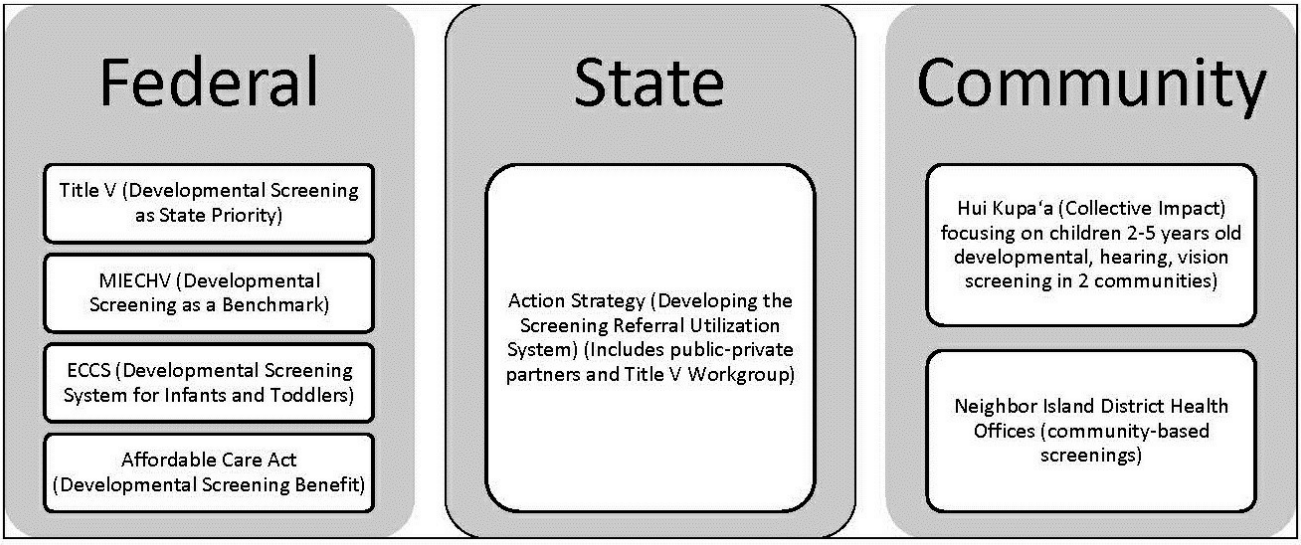
Child Health - Plan for the Application Year

Preliminary Five Year Plan: Developmental Screening

Hawaii continues to focus on developmental screening as a state priority issue based on results of the 5-year needs assessment. At both the state and federal levels, developmental screening has surfaced as a lever to help improve the health and well-being of children and families. Work continues on the findings of the public-private partnership led by the Governor's Office Action Strategy for Hawaii's Children which identified a priority on establishing a universal, voluntary screening-referral-utilization system starting with developmental screening (DS) of young children birth through age 5. Hawaii has also been working on a collective impact model of public private partnership which identified developmental, vision, and hearing screening as a priority affecting the school readiness of young children. The Hawaii Chapter of the American Academy of Pediatrics (HAAP) identified developmental screening beginning at infancy through the early elementary school years as a priority.

At the federal level, Health Resources Services Administration (HRSA) awarded Hawaii an Early Childhood Comprehensive Systems (ECCS) grant focusing on developmental screening activities of young children birth through age 3. This grant works in partnership with the Maternal Infant Early Childhood Home Visiting (MIECHV) which has a benchmark focusing on the percentage of children who have received developmental screening and coordination and referral for services.

Federal, State, and Community Initiatives focusing on Developmental Screening



Priority: Improve the percentage of children screened early and continuously age 0-5 years for developmental delay. The state priority is based on the Title V block grant guidance National Performance Measures for developmental screening on children. In the previous 5-Year project period developmental screening of children was identified as a Title V priority, so this is a continuing priority issue for children.

Objective:

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

The preliminary 5-year plan objectives were developed using the Title V website data from the National Survey of Children's Health data as a baseline and projecting a three percent improvement over the next five years.

National Performance Measure: Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool.

5-Year Strategies:

1. Training & Technical Assistance.Develop infrastructure for on-going training, technical assistance, and support for practitioners conducting developmental screening activities.
2. Policy & Advocacy. Develop protocols, guidelines and standardized referral processes, and communication system on developmental screening.
3. Data & Evaluation.Develop data system to track and monitor screening, referral, utilization system.
4. Family Engagement.Develop collateral material needed to support understanding and importance of developmental screening.
5. Service System.Develop website to house materials, information, and resources on developmental screening.

Strategy Development

The strategies reflect the plans of the Governor's Action Strategy workgroup "On-Track Health and Development", led by the ECCS Coordinator and the HAAP representative. This workgroup also includes staff from other Title V programs. Developmental screening is the first step in forming the voluntary screening referral utilization system. These strategies also include input from the community-level through the Collective Impact work of the group Hui Kupa'a (the Hawaiian term for "many hands working together"). Hui Kupa'a is a joint partnership between the State and Hawaii's nonprofit social service providers to address some of the state's complex social problems including homelessness and early childhood. The strategies are also included in the ECCS grant plan. Additional stakeholder input has been collected through meetings, online surveys for information and feedback, and participation at

conferences or other public events.

Plans for Application Year Federal Fiscal Year 2016 (10/1/15-9/30/16):

1. Training & Technical Assistance (TA)
    a. Identify training and TA on developmental screening needs in the community
    b. Develop training and TA package for community-based providers
    c. Work with MCH Workforce Development Center to continue Process Mapping

2. Policy & Advocacy
    a. Host discussion groups with communities to inform work plan for screening system needs in the areas of: family engagement, service delivery, policy & advocacy, data & evaluation, and training and TA
    b. Develop work plan with benchmarks and timeline
    c. Finalize screening, referral, and utilization policies for DOH programs

3. Data & Evaluation
    a. Test screening, referral, and utilization data in two communities
    b. Develop universal consent form for data sharing

4. Family Engagement
    a. Engage family groups to develop family-friendly messages on developmental screening
    b. Develop collateral material for parents, medical and early childhood providers, and the general public

5. Service System
    a. Track number of "hits" to developmental screening website.
    b. Develop systems' mapping with support from MCH Workforce Development Center.

Factors Contributing to Success

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

- Partnership with the Medical Home: The ECCS Coordinator works closely with HAAP supporting annual community meetings to bring together the early childhood and medical/healthcare communities, utilizing HAAP visiting professors. In May, Dr. Ellen Perrin, the creator of the Survey of Well-Being of Young Children, discussed her developmental screening tool and its successful implementation. While Hawaii continues to promote the Ages and Stages Questionnaire and the Parents' Evaluation of Developmental Status, the discussion on other tools proved valuable.

- Public Private Partnerships: Hawaii's non-profits and community-based organizations play a major role in supporting efforts from the State. These partnerships and relationships are crucial to developing a statewide system and ensures that the voices of the community and providers are considered. These non-profits also help sustain and build capacity in local communities. Partners include the Hawaii Association for the Education of Young Children, the Hawaii Head Start Association, PATCH (the Child Care Resource and Referral agency which provides community-based trainings statewide), and the Department of Human Services Child Care Program which oversees the Child Care Development Block Grant.

- Data & Evaluation: PHOCUSED is the Hui Kupa'a backbone organization, helping group leaders with administrative support for data sharing between families, screening providers, and PHOCUSED. Currently data sharing is being piloted for children 2-5 years old to see how many referrals are receiving services from

the Early Intervention Services program (Part C, IDEA). The data is being checked for duplicates, referral numbers, and follow up with EIS. The data will be eventually be incorporated into a state longitudinal child data system and help guide the workgroup to reach better outcomes.

- Federal Alignment: Because HRSA funds both the Title V and ECCS grant, there have been opportunities at the state level to align and combine the work on developmental screening. Because the ECCS, Title V, and the MIECHV grants are all housed within the FHSD the coordinators maintain a good working relationship. Hawaii was fortunate to be a part of the first cohort of the MCH Workforce Development Center and chose to focus on developmental screening. The team members represented ECCS, MIECHV, EIS, HAAP, and Hui Kupa'a. Through TA from the Center, the team developed process maps to show the developmental screening processes in two community based programs. The Center will work with Hawaii to develop an expanded systems' map to identify areas to support family engagement.
- FHSD supported a strategic operations planning pilot to better align and integrate its work across the Division. One of the projects from the process was the establishment of a Title V Developmental Screening Workgroup with representatives from all early childhood programs and the district health offices. This group demonstrates how programs can develop common outcomes to improve child health. A local community organization was able to conduct developmental screenings in a WIC clinic as a potential best practice statewide.

Challenges, Barriers

While there is interest and activity by many groups focusing on developmental screening, it will be important to engage with the Governor's Healthcare Transformation Office (HTO) who is overseeing the Affordable Care Act (ACA) and the Department of Human Services Medicaid agency since developmental screening is covered under both the ACA and Early Periodic Screening Diagnosis and Treatment (EPSDT). Even though developmental screening of infants and toddlers up to age 3 is a covered benefit, there is still the need for an integrated system to ensure the supports are available statewide and in each community.

- Policy: Hawaii's DOH does not have a policy on developmental screenings.As the public health agency, standard policies, guidelines, or protocols would assist community providers. This would also help the DOH work with Departments of Education and Human Services, which oversees public education, child welfare and the Medicaid program, to align efforts.While ECCS is able to point towards federal (HRSA) guidance to work on developmental screening efforts, similar guidelines from DOH is lacking. FHSD is working with partners to develop principles, protocols and guidelines for DOH consideration.

- Partnership with Medicaid: Approximately 40% of Hawaii's children are insured through Medicaid. However, EPSDT data is not readily available for analysis to assure screening and follow-up services. Only state-level utilization rates on the CMS 416 form are available.Thus, Hawaii is not able to identify disparities to target interventions.

- Affordable Care Act: Most of the State's ACA efforts focused on the development of the Health Care Exchange. Hawaii is still struggling with understanding and assuring consumers utilize the full benefits under ACA, especially with regards to developmental screening of infants and toddlers. There is no clarity regarding screening tools, follow up, and how families access habilitative services. Hawaii will continue to work with the state Office of Healthcare Transformation and health plans to develop consistent messaging to families. Infrastructure support for screening is also needed including training, data systems, and research and evaluation.

Preliminary Five Year Plan: Child Abuse and Neglect Prevention

The 5-year needs assessment reaffirmed the importance of child abuse and neglect (CAN) prevention as a

continued priority issue from the previous Title V needs assessment. CAN rates have changed little in 5-years and remains a high profile health concern with broad community support. There are numerous programs that serve families in the state and opportunities to improve system delivery through improved collaboration.
The Title V agency has a statutory role in CAN prevention and administers several major programs dedicated to CAN prevention and family strengthening, including the MIECHV grant and the CBCAP grant. These programs are housed in the MCHB, Family Support and Violence Prevention Section (FSVPS), which programs include CAN Prevention, Sexual Violence Prevention, Domestic Violence Prevention, Home Visiting, Parenting Support, and the Child Death Review.
Priority: Reduce the rate of child abuse and neglect with special attention on ages 0-5.
The state priority is a continuing priority from the previous Title V needs assessment.
Objective: By July 2020, reduce the rate of confirmed child abuse and neglect reports per 1,000 for children aged 0-5 years to 5.9% (Baseline: Center on the Family 2013 6.2).

The 5-year plan objective continues the state objective and measure from the previous Title V needs assessment.
National Performance Measure: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19.
5-Year Strategies:

- Raise awareness about the importance of safe and nurturing relationships to prevent child abuse/neglect.
- Improve evaluation capacity of Title V Family Support and Violence Prevention Section programs to assure improved outcomes.
- Improve collaboration and integration between programs addressing child wellness and family strengthening.

Strategy Development
The strategies reflect the work of the Governor's Executive Office of Early Learning Action Strategy initiative for "Nurturing and Safe Families" and portions of the planning framework utilized by the CBCAP grant. The strategies also reflect guidelines promoted by the CDC to prevent child maltreatment utilized by the Hawaii Children's Trust Fund which is staffed by FSVP staff.
Current CAN prevention activities include participating in a promising initiative convened by State Senator Suzanne Chun-Oakland to address CAN issues utilizing a systems approach. The Senator has a significant and lengthy history working with both the DOH and DHS, chairing the Senate Committee on Housing and Human Services. With new departmental leadership, the intent is to increase collaboration across the departments to develop system improvements. Staff from both departments are currently developing an inventory of family programs from primary prevention to tertiary and intervention services.
The group is documenting data needs and researching frameworks to guide the process to assure child well-being. This initiative as well as activities in process at the MCH Branch will assist the FHSD to formulate a CAN prevention plan.
The Home Visiting (HV) Program received 2 HRSA MIECHV grants totaling over $9.4M, both for the project period through 2017. The $1M Formula Grant will be used to maintain Early Identification of participants at a birthing hospital and to strengthen current HV services. The $8.4M Expansion Grant will be used to: increase enrollment of prenatal women; strengthen HV effectiveness in prenatal health and birth outcomes, school readiness, referrals to community resources; and promote sustainability through quality improvement.
The program continues to demonstrate success meeting four of the six MIECHV grant benchmark areas: maternal and newborn health; child injuries, maltreatment, and emergency department visits; school readiness and achievement; and coordination and referrals.
Because the Child Death Review (CDR) Program does not currently have dedicated funds or staffing, a CDC grant for $63K was submitted to support a Sudden Unexpected Infant Death (SUID) Case Registry grant. The notification of award is expected in September 2015. Grantees will conduct infant death reviews within 30 days of death and adopt data driven best practices and policies to reduce or prevent SUID.

The Parenting Support Program (PSP) provides contracted services that utilize the CAN prevention protective factors to encourage the development of safe and nurturing relationships between parents and children. PSP targets families who are transitioning out of homelessness or are socially isolated. Providers train on the impact domestic violence has on children and families, as well as how adverse childhood experiences impacts a parent's health and the ability to parent effectively.

FSPV programs also support the Safe Sleep Hawaii Committee and is participating in the National Institute for Children's Health Quality's Collaborative Improvement & Innovation Network (COIIN) to reduce infant mortality and sleep related infant deaths.

The CAN Prevention Program supports building systems capacity and sponsored a statewide partners meeting to promote collaboration. Participants included: FRIENDS NRC (National technical assistance for CBCAP grantees), government and community based agencies, survivors, coalition members, university faculty, and legislative staff. Community partners shared their goals and priorities to reduce CAN. The information will be used for program mapping and planning.

FHSD staff at the Neighbor Island DHO co-lead the State's Child Welfare Citizens Review Panel. The DHO staff assure collaboration with community-based programs and family engagement for DOH child and family wellness services.

Plans for Application Year FY 2016:

- The meetings convened by Sen. Chun-Oakland designed to improve coordination among family service programs will continue to identify areas for collaboration. Data needs to improve quality and assure outcomes will be documented. Plans will be developed to increase child well-being and reduce the rate of CAN.
- Title V HV, PSP, CBCAP, Safe Sleep, and DHO program activities to prevent CAN will continue.
- Plans to re-establish the CDR program will continue with training for SUID reviews.
- The Title V CAN prevention program will work with the Division epidemiologist and new CSTE MCH Epi Fellow to determine the feasibility of developing an integrated data system to evaluate program outcomes and measure the collective impact of the section's programs.

Factors Contributing to Success:

- CAN prevention is a long standing issue in child health with a high level of public awareness and support. There are numerous programs throughout that state that work with families; however, coordination across these programs is often lacking. Many of these programs are staffed by a highly dedicated and knowledgeable workforce. There is also strong legislative and administrative support for child maltreatment as a priority health concern.
- Within FHSD, there are many potential partner programs serving families including Neighbor Island DHOs, WIC, and CSHNB. Other Division resources include the ECCS Coordinator and Office of Primary Care and Rural Health.
- Hawaii has also been able to access technical assistance and resources. Title V also partners closely with the DOH Injury Prevention and Control Section. Through IPCS, Title V has been able to access TA from both the CDC and the Child Safety Network.
- CAN prevention efforts have been utilizing the new Title V guidance and activities to help initiate program collaboration efforts in the FSPV Section. The new 5-year plan template has helped focus discussions among the Title V CAN prevention programs and will help to communicate the programs' common agenda around CAN prevention.

Challenges, Barriers

While Hawaii has many dedicated CAN and family support assets, the key challenge is the lack of expertise,

leadership to develop and support coordinated service systems. Fragmentation at all levels, starting with federal funding streams, promote separate program purposes, reporting, data collection, although programs often target the same families for services and information.
Although in a formative stage, the systems improvement initiative convened by Sen. Chun-Oakland may serve as a model to promote agency collaboration and system integration in other areas.

Completing 5-Year Action Plan Activities: Developmental Screening & CAN

FHSD will continue to work on the current project discussed in the plan narratives. An update on progress will be provided in next year's Title V report. Any needed changes to the preliminary 5-Year Plan will be made. Based upon guidance provided by AMCHP and the federal MCH Bureau, performance measures will be identified for evidence based practices.

Child Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	41	41	41	41	41

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	142	142	142	142	142

For the Child population domain, Hawaii is reporting on the national and state performance measures which address the following issues:

- NPM 7: Immunizations
- NPM 10: Child Motor Vehicle Deaths
- NPM 13: Children without Medical Insurance
- NPM 14: Child Obesity
- SPM 3: Developmental Screening
- SPM 5: Child Abuse & Neglect
- SPM 11: Disparities in Childhood Obesity

NPM 7: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, & Hepatitis B.

The latest NIS data from 2013 indicate that 77.2% of children ages 19-35 months have completed the recommended schedule of immunizations in Hawaii, a slight decrease (from 85.5%) after two years of significantly low immunization

rates. The annual 2013 state objective HP 2020 goal of 80% was not met. The 2013 state indicator is comparable to the 2013 national rate of 78.7%.

The Title V agency assures health care providers monitor and track whether children are receiving immunization through service contracts. Primary care contracts with the Federally Qualified Health Centers and private providers for health and dental services to the uninsured and underinsured, Hawaii Home Visiting Network service providers, and WIC programs provide infant immunization education and referrals and collect data on immunization rates.

Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii, a Title V agency contractor, provides system building support to improve statewide perinatal services. HMHB manages the perinatal information phone line, "text4baby" service, and website which include information and resources on childhood immunizations.

Parenting support programs administered by the MCH Branch sponsors several outreach/informational services including: the Parent Line which provides informal counseling, referrals, and "Keiki 'O Hawaii" and a newsletter featuring information on early childhood development and resources for first-time parents.

The CSHN program encourages parents to get required immunizations. This information is included in the child's medical record. CSHNP may refer parents to immunization clinics operated by DOH Public Health Nursing.

NPM 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

The provisional data for 2014 is 1.7 motor vehicle (MV) related deaths for children younger than 14 years (per 100,000 children). The Hawaii objective was not met. This measure includes child deaths related to transport events as well as child pedestrians or cyclists fatally injured in a transport event. MV related injuries is the leading cause of injury death for children aged 10-14 years and the second leading cause of injury death for children aged 1-4 years and 5-9 years as reported in 2013 in Hawaii.

The Hawaii Home Visiting Network, supported by the ACA Maternal Infant Early Childhood Home Visiting grant, continues to measure the number of families who receive information or training on the prevention of child injuries as part of benchmark data reporting. Seventy-nine (79) families received information on prevention of childhood injuries and two hundred eight (208) families received training.

In addition, several Title V programs promote car seat usage with parents, may offer to conduct car seat checks, and provide assistance to acquire car seats including WIC and CSHN. WIC also provides assistance to help families acquire bicycle helmets for children which are mandated in Hawaii for children under 14 years of age.

NPM 13: Percent of children without health insurance.

In 2013 (the latest available year), the estimated percent of Hawaii's children 0-17 years without health insurance is 3.0%, representing an estimated 9,335 uninsured children. The objective was not met; the rate compares favorably to the national rate of 6.5%. In fiscal year (FY) 13 approximately 31,000 children were enrolled in CHIP, and an additional 138,000 children were enrolled in Medicaid for a total of 169,000 representing a 0.8% increase.

Hawaii continued to participate in the Children's Health Insurance Program Reauthorization Act (CHIPRA) which provides Medicaid and CHIP coverage to children and pregnant women who are lawfully residing in the United States, including those within their first five years of having certain legal status.

Hawaii's safety net includes 14 Federally Qualified Health Centers (FQHC) and their satellite sites. In 2013, the FQHCs provided care to 146,484 patients representing an increase of over 2,000 patients. Of these, 30% (43,945) were children under 18 years of age. Over half (53%) of the children were insured with Medicaid/CHIP.

Approximately 13% of 0-17 year olds were uninsured reflecting a decrease of approximately 3% from the previous year. All FQHCs assist eligible clients with Medicaid enrollment; individuals that do not meet the eligibility criteria are helped to identify other options. The Primary Care Office (PCO), under Title V, contracts the 13 FQHCs as well as three private clinics to provide comprehensive primary care services to uninsured and underinsured children, adults, and families whose income falls within 250% FPL. Services include perinatal, pediatric, and adult primary care.

The Hawaii Primary Care Association continues to support and facilitate a range of trainings for the FQHC outreach workers.

Other Division Title V programs including WIC, Children with Special Health Needs, Perinatal Support Services, and the federal Home Visiting program continued to actively work with families with children continue to provide assistance and referrals to help secure insurance coverage for children. Most direct service providers and contractors are making referrals to the Hawaii insurance Connector services supported by the Affordable Care Act.

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

The data for 2014 indicates 18.4% of WIC children ages 2-5 years were overweight or obese. The state objective was met; however, the Healthy People 2020 objective of 9.6% was not.

WIC continues to promote USDA core nutrition messages to motivate caregivers to offer whole grains, low-fat milk, and fruits/vegetables as part of family meals and snacks. WIC provides educational messages and resources on the importance of healthy weight for children.

WIC staff continue to use skills and knowledge gained from Health at Every Size® and Intuitive Eating. WIC trained neighbor island staff and community partners on breastfeeding skills utilizing the Loving Support© Through Peer Counseling: A Journey Together curriculum. WIC also continues to work with the University of Hawaii State Longitudinal Data System (SLDS) to include program data to assess and assure better health and educational outcomes for children.

The Native Hawaiian Family Child Interaction Learning Programs (FCIL) has a database which includes the number of children enrolled in their play and learn groups. One of the data sets collected involves the number of children who are in the WIC program. Hawaii's Title V workgroup is awaiting approval from the FCIL to release the information to help with planning for the mostly native Hawaiian children enrolled in their programs.

Family Health Services Division (FHSD) continues to partners with the Executive Office on Early Learning (EOEL) in developing early childhood health and wellness guidelines that will be used in early childhood programs which reaches approximately 40% of young children birth through age 5. The goal is to embed these guidelines into early childhood programs with training and technical assistance support to help prevent obesity at an early age. While these draft Guidelines were originally intended to focus on obesity prevention, Hawaii is using this opportunity to develop a comprehensive set of health and wellness guidelines for children in early childhood programs

SPM 3: The percentage of parents of children 10 months to 5 years who report completing a standardized developmental and behavioral screener (SDBS) during a health care visit in the past 12 months.

This measure reflects the State priority to increase early child developmental screening. The latest data for Hawaii indicates 38.9% of parents completed a developmental screen for their young child, an increase over 2007 survey (a trend also reflected in the national data). The objective was met. Hawaii screening rates continue to compare favorably to the U.S. (38.9 vs. 30.8).

Hawaii's Title V Developmental Screening Workgroup has merged with the Executive Office on Early Learning (EOEL) Action Strategy Group Health & Development on Track which focuses on efforts to build a system of screening, referral, and utilization.

Hawaii received an Early Childhood Comprehensive Systems (ECCS) grant from the Maternal and Child Health Bureau (MCHB) Health Resources Services Administration (HRSA) and its focus is on developmental screening activities in infant/toddler programs. Hawaii's ECCS Coordinator is working to coordinate the various screening activities across the state. The ECCS Coordinator works with the Centers for Disease Control and Prevention (CDC) Act Early Ambassador and continues to promote the free educational material developed by the CDC. During the 10/1/13 – 9/30/14 timeframe, over 400 pamphlets and brochures from the CDC was distributed to families and early childhood providers.

Hawaii has a Collective Impact effort (also known as *Hui Kupa'a*) and the Early Childhood Workgroup focuses on developmental, hearing, and vision screening in two Oahu communities using the collective impact model. Collective Impact brings together representatives from the business, non-profit, and state agencies to work together to improve outcomes for children. Representatives from Early Intervention Section and the ECCS Coordinator are principal members of this team.

Hawaii's Title V programs applied for and received a MCH Workforce Development Center grant from HRSA. Hawaii became one of the first cohort states to receive this training and technical assistance grant. Hawaii's team included: ECCS Coordinator, EIS Part C Quality Assurance Coordinator, MIECHV Home Visiting Program Coordinator, Hawaii's Family to Family Health Information Center Representative, and a representative from PHOCUSED (a non-profit advocating for social services). Hawaii's project focused on quality improvement for developmental screening and referral efforts and developed metrics for optimal outcomes.

MCHB/HRSA also funds the Maternal and Infant Early Childhood Home Visiting (MIECHV) grant. The DOH uses the MIECHV funding to help support the Hawaii Home Visiting Network to work with the existing evidence based models in Hawaii. The Hawaii Home Visiting Models all promote the use of the Ages and Stages Questionnaire (ASQ) and ASQ-Social Emotional (SE) to monitor child development.

Children with Special Health Care Needs Branch (CHSNB) administers the Hi'ilei (to carry and tend to a beloved child) program which is a developmental follow along program for young children who may not be eligible for EIS, but continue to need support.

The Title V Newborn Hearing Screening program continues screening newborns before hospital discharge.

The Fetal Alcohol Spectrum Disorder (FASD) Task Force works to improve screening and training activities.

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

This measure reflects the state priority to reduce child abuse and neglect (CAN). In 2013 (latest available data), the Hawaii CAN rate was 6.2 per 1,000 children 0-5 years of age. The 2013 state objective was met. In 2013, an estimated 9.1 per 1,000 children 0-17 years were victims of CAN in the US. In Hawaii, the rate of confirmed cases of CAN has declined over the past 9 years, but still accounted for 1,324 cases, a rate of 4.3 in 2013 (Child Maltreatment Report 2013).

The Affordable Care Act (ACA) through the Maternal Infant Early Childhood Home Visiting (MIECHV) grant and State funding supported 11 home visiting (HV) programs (5 new sites since 2013) and 5 hospital-based early identification (EID) programs within the Hawaii Home Visiting system.

The HV and EID programs within the Hawaii Home Visiting Network (HHVN) operate using three evidence-based models (Parents As Teachers, Home Instruction for Parents of Preschool Youngsters, amd Healthy Families America), as well as, two culturally-based HV models. Through the HHVN system, these participating HV and EID programs received technical assistance (TA) and infrastructure building support to ensure that HV and EID programs operate with fidelity to their model. Infrastructure support also included training and TA for programs to respond to 36 outcome measures. Reported suspected maltreatment, reported substantiated maltreatment, and first time victims of maltreatment for children in HHVN programs are 3 of the 36 outcome measures collected.

The DOH Maternal & Child Health Branch (MCHB) is the State lead for primary and secondary CAN prevention. MCHB administers the federal Community-Based Child Abuse and Prevention (CBCAP) grant and serves as the coordinating agency for programs that provide a range of child abuse and neglect prevention services. CBCAP contracts with Prevent Child Abuse Hawaii (PCAH) to facilitate the Child Abuse Prevention Planning (CAPP) Council to support year-round public awareness activities, including Child Abuse Prevention Month in April and Children & Youth Day in October. PCAH and the CAPP Council also support advocacy building, community engagement, training and professional development, as well as, promoting the protective factors framework to support parents. The Council meets monthly and brings together a wide spectrum of prevention partners from the public and private sector statewide, including each branch of the armed services.

MCHB is the public sector lead agency for the Hawaii Children's Trust Fund (HCTF). Established in 1993 as a public-private partnership to support family strengthening programs aimed at preventing CAN, the HCTF is comprised of an Advisory Board (AB), Advisory Committee (AC), and a Coalition of community members committed to reducing the incidence of CAN in Hawaii. The Director of Health serves on the AB, a DOH appointee serves on the AC, and MCHB provides administrative support to the AC and Coalition. In 2013, strategic planning identified key priorities areas and mechanisms for implementation. In 2014, HCTF awarded ten three-year grants to community agencies statewide to support direct services, coalition building, and the training of trainers to promote the protective factors. Grants are administered and monitored through the Hawaii Community Foundation, the

designated lead agency from the private sector.
In 2014, MCHB staff provided leadership and staffing to support the Executive Office of Early Learning's (EOEL) Action Strategy work. The Safe and Nurturing Families Team ("the Team") will center their focus on primary prevention, and efforts will be strengths-based, to reduce the incidence of family violence (FV) in the home. FV is inclusive of domestic violence, sexual violence, interpersonal violence, as well as, CAN. The Team's task is to raise awareness of the importance of utilizing resources that will make families stronger, as research supports the correlation and connection between safe families and on-track brain development and learning. Activities in the work plan include:

- Mapping of family resources statewide;
- Identification of training curriculum for early educational center providers and families;
- Identification of partners to promote training;
- Selection of early childhood education center pilot site(s);
- Evaluation, assessment, and selection of a current public awareness campaign to advance a high impact primary prevention messaging initiative; and
- Promotion of TA and guidance from national resources network of partners.

The mapping of resources has begun with the state Departments of Human Services (DHS) and Health (DOH). The inventory database will be expanded to include programs funded by other state agencies; to eventually include community-based programs funded by other means.
MCHB also administers Parenting Support Programs (PSP) Parent Line, a free, statewide telephone line and website that provides support, encouragement, informal counseling, information, and referral to callers experiencing concerns about their children's development and behavior or who have issues regarding family stresses or questions about community resources. Mobile Outreach is another PSP contract which is designed to provide activities and developmental programs to isolated or homeless families to promote age-appropriate parent-child interaction, and communication.
The WIC and Children with Special Health Needs program work closely with at-risk families and assist families to address problems/issues that generate undue stress hardship for the families where possible. Referrals are often made to access services and resources including respite care.

SPM 11: Percentage of Native Hawaiian and Other Pacific Island (NHOPI) children, ages 2-5 years receiving WIC services with the Body Mass Index (BMI) at or above the 85th percentile.

This measure reflects the State priority to reduce the obesity rate in young children ages 0-5 years with a focus on the Native Hawaiian and Other Pacific Islander (NHOPI) children. The 2014 WIC data indicates 21.4% of NHOPI children 2-5 years were overweight or obese. The 2014 WIC data is roughly equivalent to rates reported for previous years.
Hawaii chose this state performance measure based on a review of the data where NHOPI children were found to have the highest rates of overweight/obesity. Adult and adolescent data in Hawaii has also shown substantially increased estimates of obesity among NHOPI compared to other groups. There are many factors that contribute to this and the disparity is reflected in the WIC data used for this measure. Key stakeholders, such as the state Office of Hawaiian Affairs, 'Eleu (Early Childhood Native Hawaiian groups), and Papa Ola Lokahi (Native Hawaiian Health Care System) are interested in the data and will be important partners in future activities.
Besides the EOEL early childhood health and wellness guidelines, the Healthy Hawaii Initiative (HHI) within the DOH is also focusing on obesity prevention efforts in child care programs and has been assisting with the development of the Early Childhood Health and Wellness Guidelines. The University of Hawaii's Children's Healthy Living (CHL) Program for Remote Underserved Minority Population in the Pacific Region has also participated in the development of these guidelines.
WIC continues to use and distribute the children's book "Move 'Um" developed by the Honolulu Community Action Program. WIC also continues to give families the Sesame Street Workshop's "Healthy Habits for Life" kit and is exploring coordination with early child care centers to ensure a consistent message. WIC nutritionists and the

breastfeeding peer counselor conducted breastfeeding training on three islands (Kauai, Oahu, and Hawaii Island). The workshops targeted home visitors, early childhood practitioners, and public health nurses to support those who work with mothers and caregivers in their efforts to breastfeed their babies.
FHSD along with other perinatal partners formed the Hawaii Maternal Infant Health Collaborative (HMIHC) and is addressing disparities amongst prenatal and infant health. One of the areas that the group will be focusing on is the NHOPI disparity with regards to obesity prevention efforts.

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Improve the healthy development, health, safety, and well-being of adolescents	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%)	• Promote current “Bright Futures” guidelines for adolescents. • Incentivize providers, adolescents & parents to encourage preventive care. • Encourage teen-centered health care. • Leverage missed opportunities to increase adolescent preventive services. • Develop partnerships with key community stakeholders.	Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000 Percent of children with a mental/behavioral condition who receive treatment or counseling Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			

Adolescent Health

Adolescent Health - Plan for the Application Year

Preliminary 5-Year Plan

The 5-year needs assessment reaffirmed the importance of adolescent well-being as a priority issue. Adolescence

is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs.

Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. Adolescent health visits are recognized as an important standard of care. The Bright Futures guidelines recommend that adolescents have an annual checkup starting at age 11. The visit should cover a comprehensive set of preventive services, such as a physical examination, discussion of health-related behaviors, and immunizations. It recommends that the annual checkup include discussion of several health-related topics, including healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety.
The Hawaii Chapter of the AAP recently adopted improving access to adolescent care as one of its priorities. The Hilopa`a Family to Family Information Center (F2FHIC) has also made adolescent preventive visits a key priority. F2FHIC has developed materials and provides education/training to health providers and consumers on adolescent health. Surveys of Hawaii adolescent providers show serious interest in working to improve adolescent access to health care given expanded prevention benefits covered under the Affordable Care Act. Focus groups with Hawaii youth validate that teens have an alarmingly low awareness of the importance of preventive health care and many do not know their medical home provider.
Data from the National Survey of Child Health (NSCH) 2011-2012 showed the rate of Hawaii for adolescents, ages 12 through 17 with a preventive medical visit in the past year was 82.2% which is a slight decrease from the previous 2007 survey (87.9%). The Hawaii rate was comparable to the national rate of 81.7%. Given Hawaii's high level of insurance coverage due to the mandated employer based insurance coverage, it is somewhat surprising the Hawaii rate is not significantly better than the U.S.
Also key disparities exist for access to preventive care in Hawaii for adolescents. Rates for non-English speaking, those born outside the U.S. and those residing in rural areas have significantly lower rates. Moreover, Hawaii EPSDT data shows a dramatic decrease of health visits as children reach adolescence.
The 2013 Youth Risk Behavior Survey data showed that 46% of middle school aged adolescents and 62.2% of the high school teens saw a doctor for a check-up or preventive physical exam. 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 preparticipation athletic evaluations and chronic disease management, to provide other preventive services like early identification of risk behavior and disease, reproductive health assessments, updating immunizations, or offering health guidance.

Priority: Improve the healthy development, health, safety, and well-being of adolescents.
The state priority is based on the Title V National Performance Measures to promote preventive care for adolescents and reflects the interest of key adolescent health partners and Title V programmatic resources that largely focus on teen pregnancy prevention. This is a new priority for Hawaii.

Transition to Adult Health Care and Establish Medical Homes
Hawaii elected to continue work on the state priority to improve the percentage of youth with special health care needs (YSHCN) ages 14-21 years to make transitions to adult care. The national performance measure for transition services addresses both youth with and WITHOUT special needs. The Title V Adolescent Health Coordinator will coordinate efforts with the CSHN program to address both adolescent health performance measures. (See the Plan narrative for the Children with Special Health Needs Domain for plans to improve transition services for all

adolescents).

Objective:

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

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

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

5-Year Strategies

- Promote current “Bright Futures” guidelines for adolescents.
- Incentivize providers, adolescents & parents to encourage preventive care.
- Encourage teen-centered health care.
- Leverage missed opportunities to increase adolescent preventive services.
- Develop partnerships with key community stakeholders.

Strategy Development

These strategies are derived from Center for Medicare and Medicaid Services (CMS) guidelines for states to increase adolescent preventive health care. The CMS guidelines also complement the national Office of Adolescent Health’s Think, Act, Grow (TAG) Call to Action designed to promote adolescent health through a comprehensive approach with varied stakeholders including-parents; professionals; businesses and policymakers; and adolescents themselves.

Plans for Application Year Federal Fiscal Year 2016 (10/1/15-9/30/16)

- Conduct focus groups with adolescents to identify barriers and incentives to access preventive services.
- Partner with key health professional and adolescent provider stakeholder organizations to identify and address the barriers to adolescent preventive care.
- Assess parent and family awareness regarding adolescent preventive health care and barriers to accessing care to inform strategy development.
- Identify evidence based strategies and pursue opportunities for implementation.

Title V will focus its work over the next year establishing partnerships around the priority to improve adolescent well-being with particular focus on increasing adolescent wellness visits. Title V will also continue assessment activities to collect data and research on evidence based approaches to inform strategy development.

In an effort to secure resources for implementation of an evidence based strategy using text messaging, Title V was part of a project team that submitted a grant proposal to the federal Office of Adolescent Health for the Tier 2B funding opportunity to conduct a Rigorous Evaluation of an Innovative Approach to Prevent Teen Pregnancy. Project team members included the University of Hawaii Center on Disability Studies (UHCDS) and the Hawaii Pediatric Association Research and Education Foundation. While approved but not funded, the Title V project team will continue to pursue grants to explore ways to increase preventive services by adolescents.

Factor Contributing to Success

Among the 6 population domains, adolescent health has the most limited staffing/resources in the Hawaii Title V agency. Virtually all adolescent program efforts are directed toward administration of federal teen pregnancy prevention grants. In recognition of this, Title V partnered with the MCH LEND program to conduct adolescent focus groups and provider surveys to assist with needs assessment activities. The LEND program faculty will remain a critical partner to successfully identify and implement activities for this measure.

Other partners and key stakeholders who will be critical to develop systems level strategies to improve adolescent well visits include:

- the University of Hawaii’s Center on Disability Studies (UHCDs) research and evaluation team,

- the Hawaii Pediatric Research and Evaluation Foundation (HPREF),
- Hilopa`a Family to Family Information Center (F2FHIC) and
- the Hawaii Medical Services Association (HMSA), the state largest health insurer, and
- Hawaii Youth Services Network (HYSN).

Key state agency partners who work with youth include the:

- Office of Youth Services (OYS),
- Office of the Attorney General (AG),
- DOH Child and Adolescent Mental Health Division (CAMHD)
- DOH Alcohol and Other Drugs Division (ADAD),
- DOH Injury Prevention and Control Section (IPCS),
- City & County of Honolulu Parks and Recreation (HPR) and
- Department of Education's (DOE) health education resource teachers and counselors.

Title V will also explore partnering with new partners including Accountable Care Organizations.

Challenges, Barriers

Securing adequate resources (including dedicated staffing, funding, and leadership) to assure progress for this effort will remain the greatest challenge for FHSD.

Completing 5-Year Action Plan Activities

FHSD will continue to 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 preliminary 5-Year Plan will be made. Based upon guidance provided by AMCHP and the federal MCH Bureau, performance measures will be identified for evidence based practices.

Adolescent Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	86	86	86	86	86

For the Children with Special Health Needs (CSHN) population domain Hawaii is reporting on the national and state performance measures which address the following issues:

- NPM 8: Teen births
- NPM 16: Adolescent Suicide

NPM 8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

The 2014 data indicate a rate of 9.6 live births per 1,000 teenagers aged 15-17 which met the State objective of 11 per 1,000. The State continues to improve each year. The comparable Healthy People 2020 objective for this measure is to reduce pregnancies among females aged 15-17 years to no more than 36.2/1,000 females 15-17. Hawaii exceeded the HP 2020 objective (18.0 for 2012, latest available data). Of all 4 counties, Hawaii County teen birth rates are consistently higher than the state average.

In Hawaii in 2013, 35.9% of high school students reported ever having sexual intercourse, and 24.8% of those who ever had sex reported being currently sexually active - both percentages are lower than the national averages. However, among those who ever had sex, 54.1% did not use a condom at last sexual intercourse compared to 40.9% nationally, putting them at increased risk for both pregnancy and sexually transmitted infections. Alcohol or drugs were commonly associated with last intercourse among more than one in five students both nationally

(22.4%) and in Hawaii (24.0%).
Efforts to implement and promote teen pregnancy prevention (TPP) by replicating evidence based curricula continue. Three federal TPP grant awards were made to Hawaii in the past few years including the Title V program. The MCH Branch (MCHB) administers the Personal Responsibility Education Program (PREP) grant and the Abstinence Education Program (AEP) formula grants that target youth at greatest risk of teen pregnancy (TP) and areas with high teen birth rates.
The PREP grant targets services to Hawaii County teens where 7 out of 8 school districts exceeded the state's average percentage of births to teen mothers. Because of the high teen birth rate, the PREP grant was sub-awarded to Hawaii County's Prosecuting Attorney's Office to provide county-wide community-based services. The Teen Outreach Program (TOP) is a teen club model for adolescents 15-19 years old. The Youth Challenge Academy (YCA), a 26 week residential facility, formed the first 2 TOP clubs with 26 of 32 cadets completing the program. TOP is a teen club community-based program model with an integrated teen pregnancy prevention, life skills and community service learning curriculum. The PREP grant has been extended for two additional years.
The AEP grant is in its third year on Oahu and has been extended an additional year. The after school program began classes at the Spalding Clubhouse in urban Honolulu and the NFL Youth Education site in Nanakuli, a rural Oahu community with a large Native Hawaiian population. Pre-post surveys for more than 50 participants showed that 90% of participants had increased knowledge, attitudes, behaviors and skills on the sexual health content presented.
MCHB's Family Planning Program (FPP) health educators work in collaboration with FPP contract providers and the Department of Education's (DOE) health education resource teacher to adapt existing evidence-based, reproductive health curricula to be used in the schools. The 10 FPP health educators provide statewide outreach services and provide content support to the PREP and AEGP facilitators in class work.
FPP will continue to monitor provider contracts; provide training and technical support; work with Title V to reach disparate populations; and address the need for culturally relevant approaches to reproductive health.
The MCHB Adolescent Wellness Program staff serves on the Hawaii School Health Survey Committee, which is convened jointly by the Department of Education (DOE) and Department of Health (DOH). The University of Hawaii's Curriculum Research & Development Group (CDRG) is contracted to conduct the survey. DOH provides epidemiological and programmatic guidance/expertise. The committee supports the administration and implementation of population-based health surveys in schools to monitor risk behaviors that contribute to mortality, morbidity and social problems among youth. The Committee is preparing for the administration of the 2015 YRBS.

NPM 16: The rate (per 100,000) of suicide deaths among youths 15-19.

The provisional data for 2014 is 8.2 suicide deaths per 100,000 youth aged 15-19. The state objective of 8 was nearly met. The 3 year average rates appear to be slightly decreasing from 2007.
Generally, the Youth Risk Behavioral Survey (YRBS) data shows similarities in Hawaii's youth and their mainland counterparts. In 2013, 16.9% of Hawaii's high school youth reported considering attempting suicide, similar to 17% of their peers nationally. However, there was a significant increase in reported suicide attempts (10.7% up from 2011 8.6%) as compared to their mainland counterparts at 8.0%.
The Prevent Suicide Hawaii Task Force (PSHTF) is under the guidance of the DOH's Injury Prevention Control Section (IPCS). PSHTF is a state, public, and private partnership consisting of individuals, organizations, and community groups. Membership includes public and private agency members such as the Department of Education (DOE), Honolulu Police Department (HPD), the University of Hawaii, School of Psychiatry, the DOH Child and Adolescent Mental Health Division, Adult Mental Health Division, Emergency Medical Services (EMS) and others interested or with a stake in suicide prevention. There are PSHTFs in the four counties: Hawaii, Maui, Kauai and Honolulu and the chair persons of each county task force and community groups and organizations actively participate and support suicide prevention activities throughout the state. The MCHB's Adolescent Health Coordinator represents Title V on the Honolulu County and PSHTF and the Neighbor Island DOH FHSD public health nurses represent Title V on their Hawaii, Maui and Kauai task forces.
The mission of PSHTF is to prevent suicide by raising awareness, eliminating stigma, and supporting those at risk

of, or affected by, suicide. According to IPCS, for every child 10 to 19 years of age who dies from suicide in Hawaii, there are 5 who are hospitalized, and another 12 who are treated in emergency departments for nonfatal self-inflicted injuries each year. The goal of the PSHTF is to reduce the incidence of suicides and suicide attempts in Hawaii. PSHTF efforts will continue to focus on building capacity for suicide prevention activities and sustain training on the neighbor island counties. An example of neighbor island task force activities includes a consortium of safeTALK trainers on Hawaii Island. The intent of this group is to collaborate with community-based agencies to have safeTALK become an integral part of communities, including within the DOE system. The Title V neighbor island staff participates in these coalitions.

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
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.	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]	• Collaboration: - Convene agency and community stakeholders to develop strategies to improve services for adolescents and their families necessary to make transition to adult health care. Include youth in the planning process. - Collaborate with stakeholders and reach out to new stakeholders to increase awareness of the importance of health care in transition planning. - Collaborate with the Hilopaa Family to Family Health Information Center Director (also MCH LEND Co-	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health	Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care		

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		Director) in working with health care providers. - Collaborate with the FHSD/MCH Branch/Adolescent Program in working to increase the percent of adolescents age 12-17 years with a preventive medical visit in the past year, and include the transition to adult health care message. - Develop and implement plan to address key factors (e.g., medical home, health insurance, preventive medical visit, etc.) that support the transition to adult health care. • Education: - Develop educational materials to “chunk” manageable steps for transition for younger ages. - Continue to				

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		provide transition materials to other agencies to incorporate into their programs. - Provide education/training on transition to adult health care • Staff development: Promote staff development in transition issues via webinars, trainings, etc. • Potential opportunities: Investigate the inclusion of transition in other FHSD services/contracts.				

Children with Special Health Care Needs

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

Preliminary 5-Year Plan

The 5-year needs assessment affirmed the importance of transition to adult health care as a priority issue. 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. Health and health care are major barriers to making successful transitions.

Transition to adult health care remains an important issue at the national level. In 2011, the American Academy of Pediatrics (AAP), American Academy of Family Physicians, and American College of Physicians jointly published "Clinical Report – Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home". In 2015, Federal Partners in Transition Workgroup published "The 2020 Federal Youth Transition Plan: A Federal Interagency strategy", which emphasizes the importance of interagency collaboration and takes an Inclusive

approach to improve adult outcomes. A Healthy People 2020 Objective (DH-5) focuses on increasing the proportion of youth with special health care needs whose health care provider has discussed transition planning from pediatric to adult health care.

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

- Hawaii data from the National Survey of Children with Special Health Care Needs (NSCSHCN) 2009/10 showed that the Hawaii rate for transition (37.3%) was lower than the national rate (40.0%).The Hawaii rate for this measure was 39.4% in 2005/6 and 37.3% in 2009/10, but estimates may not be comparable since the survey method added cell phones in 2009/10.
- Professional and state/community agencies and organizations are interested in transition:
  - 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 Family to Family Health Information Center (F2FHIC) has developed materials and provides education/training on transition to adult health care.
  - Transition fairs have been held throughout the state.On the island of Oahu, planning has involved the FHSD/Children and Youth with Special Health Needs Section, Community Children's Council Office, DOH/Developmental Disabilities Division, Hawaii MCH Leadership Education in Neurodevelopmental and Related Disabilities [MCH LEND] Program, Hawaii State Council on Developmental Disabilities, Hawaii State Department of Education (DOE), Hilopaa F2FHIC, Special Parent Information Network (SPIN), and other agencies/organizations.
  - The 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.

Priority: Transition of Youth to Adult Health Care
The state priority is based on the Title V National Performance Measures for transition to adult health care for youth with and without special health care needs. The focus on the transition of children with special health care needs to adult health care is a continuing priority for Hawaii. The focus on the transition of children without special health care needs to adult health care is a new priority for Hawaii.

Objective: By July 2020, increase the percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care to 40%. [Baseline: Hawaii 37.3%, National Survey of CSHCN (NSCSHCN) 2009/10)

The preliminary 5-year plan objectives were developed using the NSCHCN data for Hawaii as a baseline and projected an almost 3 percent improvement over the next five years.

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

5-Year Strategies

- Collaboration:
  - Convene agency and community stakeholders to develop strategies to improve services for adolescents and their families necessary to make transition to adult health care.Include youth in the planning process.
  - Collaborate with stakeholders and reach out to new stakeholders to increase awareness of the importance of health care in transition planning.

    - Collaborate with the Hilopaa Family to Family Health Information Center Director (also MCH LEND Co-Director) in working with health care providers.
    - Collaborate with the FHSD/MCH Branch/Adolescent Program in working to increase the percent of adolescents age 12-17 years with a preventive medical visit in the past year, and include the transition to adult health care message.
    - Develop and implement plan to address key factors (e.g., medical home, health insurance, preventive medical visit, etc.) that support the transition to adult health care.
- Education:
    - Develop educational materials to "chunk" manageable steps for transition for younger ages.
    - Continue to provide transition materials to other agencies to incorporate into their programs.
    - Provide education/training on transition to adult health care.
- Staff development: Promote staff development in transition issues via webinars, trainings, etc.
- Potential opportunities: Investigate the inclusion of transition in other FHSD services/contracts.

Strategy Development

Strategies were developed based on recommendations from national reports as well as discussions at the local level. The 2020 Federal Youth Transition Plan and other reports recommend closer collaboration among providers working with transitioning youth. Many agencies have been working on transitioning their clients to adult life. Most work separately, without consulting others in the youth's circle of support. The 2020 Plan also recommends quality professional development for staff engaged in providing services to youth. In 2014, the CMS report on Paving the Road to Good Health recommended developing partnerships among key stakeholders and creating adolescent-friendly material.

Plans for Application Year Federal Fiscal Year 2016 (10/1/15-9/30/16)

Much work centers on establishing or continuing partnerships to reach wider audiences, to spread resources and expertise, and to develop youth-friendly material.

- Continue Footsteps to Transition/Big MAC (Moving Across Community)/other transition awareness planning involvement.
- Participate in other large well-established events, such as SPIN Conference, in which participants include youth with special needs and their families.
- Support professional development opportunities to develop competencies in addressing transition issues, via webinars, trainings, conferences, etc.
- Collaborate with FHSD/Adolescent Program to infuse transition planning into their established networks and contracts.
- Assist in supporting Medicaid Buy-in, which was not approved by legislature.
- Research public/private insurance coverage for yearly physical exams for adolescents, and review recommendations from the AAP.
- Collaborate and broaden partnerships to increase awareness of multiple facets of transition to boost successful outcomes.Partnerships may include the Hawaii Immunization Coalition, Project Laulima, Medicaid Buy-in Task Force, Public Health Nursing, and stakeholders in youth/health/service network.Utilize the partnerships to educate participants about the importance of transition to adult health care.
- Develop catchy information materials to use with younger-aged children and their families.Develop a transition brochure with local appeal.

Factors Contributing to Success

Strong encouragement from the Federal level to include transition in agency services has helped to heighten recognition that good transition planning and execution improve adult outcomes. Resources are available (and free)

for health providers, community, and youth/family use. Multiple transition booklets, tips, and recommendations can be found on various nationally-endorsed websites. The national Got Transition website has current transition materials for community providers. The 2020 Federal Youth Transition Plan on enhanced interagency coordination will help to make transition more integrated leading to improved outcomes.

In Hawaii, DOE requires that all high school students have a Personal Transition Plan to transition from high school to college and careers. DOE has also co-sponsored and hosted transition events. QUEST Integration AlohaCare recommends that physicians expand school and sports physicals to meet the criteria of a well-care screening. Their website includes information on adolescent health. MCH LEND and Family Voices continue to promote and educate future/current providers and leaders in the field in the art and science of Transition.

Challenges, Barriers

There are many challenges in addressing transition. However, introducing the idea earlier and in smaller chunks over a longer period of time may mitigate some barriers.

- Families are busy with life, work, their other children, etc.There can be a huge physical and emotional toll of having a family member with a special care need.
- Providers and families are still learning about the importance of transition planning.Preparation for independence, responsibility, and transition is often addressed later, rather than sooner.
- Youth may be connected to multiple systems of care that don't talk to each other, which may make coordination confusing.
- Providers have limited time with clients, have limited staff, and may not feel competent in discussing issues.Until recently, coding for reimbursement was problematic.
- The process needs to be individualized and (if possible) youth needs to have input into the process (self-determination).
- Benefits planning takes skill and expertise.However, low cost/free consultations are limited.Persons with disabilities often need the full coverage of public insurance; they cannot afford to earn "too much" and lose their eligibility.

Completing 5-Year Action Plan Activities

FHSD will continue to work on the current activities discussed above. An update on progress will be provided in next year's Title V report. Any needed changes to the preliminary 5-Year Plan will be made. Based upon guidance provided by AMCHP and the federal MCH Bureau, performance measures will be identified for evidence-based practices.

Children with Special Health Care Needs - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	39	39	39	39	39

For the Children with Special Health Needs (CSHN) population domain Hawaii is reporting on the national and state performance measures which address the following issues:

- NPM 2: CSHN family decision-making & satisfaction

- NPM 3: Medical Home
- NPM 4: CSHN medical insurance coverage
- NPM 5:CSHN community based services
- NPM 6:.CSHN transition services
- SPM 9: YSHN transition to adult care

NPM 2: The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive.

Data from the National Survey of CSHCN show that 77.6% of Hawaii CSHCN families partnered in decision making and were satisfied with services compared to 70.3% nationally. Families of children with special health care needs (CSHCN) were involved in decision-making in various ways: as advisory committee members; developing parent education materials; in presentations and panels; interviewing applicants for staff positions; advocacy for legislation; and providing input on program policies and procedures. Parents were compensated or assisted by providing stipends, transportation and child care costs.

The Hawaii Early Intervention Coordination Council (HEICC) advises the DOH regarding early intervention (EI) services. As required by Part C of the Individuals with Disabilities Education Act, the HEICC has parents of CSHCN as members. A Co-Chair of the HEICC is a parent of a youth with special health care needs (YSHCN).

Early Intervention Section (EIS) supports families attending conferences and trainings by paying registration fees, including airfare & ground transportation for Neighbor Island families to come to Oahu, EIS continues to obtain feedback from families through meetings, committees, and an annual family outcome survey.

The Newborn Hearing Screening Program (NHSP) provides parent support to families with children who did not pass newborn hearing screening or who had confirmed hearing loss. Family members participate on the Early Hearing Detection and Intervention (EHDI) Advisory Committee. The Hawaii Chapter of the national parent organization, Hands & Voices (H&V) has been established. NHSP will contract HV to provide parent supports to families. NHSP collaborated with the H&V Hawaii Chapter and the Early Intervention Program to offer parent education and parent support activities.

Family members of children with metabolic conditions participate in Newborn Metabolic Screening (NBMS) Advisory Committee and task forces as new conditions are considered for addition to the newborn screening panel of disorders. Most recently, families had a voice in the decision to start testing all of Hawaii's Newborns for the genetic disorder SCIDS (Severe Combined Immunodeficiency Syndrome). Families of children with genetic conditions participate in State Genetics Advisory Committee and as an integral partner in Western States Genetic Services Collaborative (WSGSC).

The family resource handbook in Children with Special Health Needs Program (CSHNP) includes a Transition section to develop a Family Individual Plan (FIP) for services. The Transition Checklist tool and FIP are developed together with children and their families. Plan components are reviewed annually with the family to address current and emerging concerns. CSHNP also partners with the Arc, Hawaii Department of Education (DOE), Hilopa'a, Developmental Disabilities Branch, Special Parents Information Network (SPIN), Childrens Community Council (CCC) and Best Buddies to host annual transition fairs in the community.

CSHNP coordinates a Hawaii Island Kardiac Kids support group that serves as an active resource for children and parents. The Oahu Kapiolani Kardiac Kids parent support group also provides mentorship and support to the Hawaii Island group. Teen mentorship club members provide positive peer support and speakers for community group events. Teens have their own officers and are encouraged to make an impact in the community. Participants are taught lifestyle management and plan fun group outings.

Children with Special Health Needs Program (CSHNP) works closely with parents of children with orofacial birth defects (cleft lip and palate) to make changes in medical/health insurance coverage. Medicaid and Tricare already provide medical coverage for medically necessary orthodontic treatments for these children as it is part of the reconstruction of the birth defect and would address functional problems such as biting, chewing, speech and respiration. For children covered by commercial/private health plans the high cost of repeated orthodontic treatment

is an out of pocket expense. Parents, medical, dental and community stakeholders collaborated with CSHNP to support legislation to expand insurance coverage for these services. Parents participated in the legislative process by submitting testimony for proposed bills, meeting with the legislators and the creation of a Facebook page, "Lifetime of Smiles", to inform others of this issue. Lifetime of Smiles is also the name of the informal parent support group of parents and their children who have orofacial birth defects. CSHNP has provided leadership, guidance, updates and coordination of these activities but the strength of these activities have come from partnerships with parents who are directly affected by inadequate insurance coverage for medically necessary treatment. Efforts by CSHNP and parents resulted in the successful passage of legislation in 2015 to include orthodontic treatments for these children into all insurance plan benefit packages. The bill was recently signed by the Governor at a public ceremony with the families, legislators, and Title V staff.

Title V participates in the annual Special Parent Information Network (SPIN) conference to provide information on health issues, services, and opportunities to participate in CSHN programs.

NPM 3: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, and comprehensive care within a medical home.

Data from the National Survey of Children with Special Health Care Needs (CSHN) show that 45.4% of Hawaii CSHN had a medical home compared to 43% nationally.

The Children with Special Health Needs Branch (CSHNB) supports medical homes by assisting families with access to specialty services. Pediatric cardiology, neurology and nutrition clinics are provided in neighbor island districts where those services are otherwise unavailable. CSHNB expanded access to cardiology services in West Hawaii. The West Hawaii CSHNB social worker is able to support cardiac clinic services in conjunction with client medical homes. Financial assistance for medical specialty services and neighbor island travel is provided to eligible children. CSHNB provides information and referral, outreach, service coordination, social work, audiology and nutrition services for CSHCN age 0-21. Title V Workgroups on Early Childhood Development/Screening and Transition to Adult Health Care continue efforts to improve access to services for families in collaboration with community partners.

CSHNB is part of the Kapi'olani Medical Center Cleft and Craniofacial Center multi-disciplinary team which sees patients weekly. Parents are given guidance on issues and concerns to discuss with their medical home. The goal is to enable parents to understand the needs of their children so they can communicate and coordinate services with their medical home. In situations where parents require more assistance, direct coordination is done with their medical home and specialists.

The Newborn Metabolic Screening Program (NMSP) provides metabolic screening to all newborns, collaborates with the medical home for follow up and has "Hawaii Practitioner's Manual" posted on their website. The Early Intervention Services (EIS) includes care coordination and involves the medical home in the Individual Family Support Plan conferences with family consent.

The Genomics Program facilitates in person and telemedicine genetics consultations on all islands. The Program is working with neighbor islands to increase referrals for telemedicine genetics consultations. The Western State Genetic Services Collaborative (WSGSC) is working with local and regional medical home advocates to improve primary care provider genetics education and ability to determine the need for referral to a genetics specialist. WSGSC will continue to participate in the national Health Resources and Services Administration (HRSA) efforts to integrate family history and genetics knowledge into medical homes.

In response to a change in Early Intervention program eligibility guidelines in 2013, Hi'ilei Hawaii was created as a safety net developmental follow along program for young children. Hi'ilei Hawaii provides developmental follow-up for young children who are high risk and not eligible for Early Intervention services. Hi'ilei provides screening results to the medical home and involves the medical home when there are referrals to early intervention services or to DOE preschool special education.

The Early Childhood Comprehensive Systems (ECCS) Coordinator is one of the co-leaders for the Executive Office on Early Learning (EOEL) strategic action group addressing the health and development of children prenatal to age 8. The key role of the Medical Home is recognized in the plan activities and outcomes.

On the Neighbor Islands there are challenges securing medical homes for CSHN given shortage of providers. CSHNP staff provide enabling services in coordination with the medical home to secure transportation services for flights to access care on Oahu given limitation of insurance coverage and accessibility issues with the planes for CSHN. CSHN staff also provide case management services at the request of the medical home to assure families keep provider appointments and comply with medication schedules.

The WIC program works to assure all clients have a medical home and insurance coverage through the Health Insurance Exchange. Referrals are also made to federally qualified health centers for care.

NPM 4: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.

Data from the National Survey of Children with Special Health Care Needs (CSHCN) show that 72.6% of Hawaii CSHN had adequate insurance coverage to pay for needed services compared to 60.6% nationally. The study also reported 5.3% of CSHCN were without insurance at one or more periods and 94.7% were consistently insured the entire past 12 months.

Children with Special Health Needs Program (CSHNP) service coordinators assisted CSHCN and their families obtain and maximize use of health coverage. CSHNP provided financial assistance for medical specialty, laboratory, x-ray, hearing aids, orthodontic treatment, neighbor island air/ground transportation, lodging, and specialty clinics on Kauai, Maui, and the Big Island. CSHNP administered the Hawaii Lions Foundation Uninsured/Under-Insured Fund for hearing and vision services.

Newborn Metabolic and Hearing Screening Programs provided outpatient screening and diagnostic evaluations for families who could not afford the cost. Hospital screening is generally covered by insurance.

CSHCN with family income up to 300% are eligible for Medicaid services under QUEST managed care or under QUEST Expanded Access (QExA) for individuals who are aged, blind, or disabled (ABD). QExA, began in 2009, provides a comprehensive package of medical, dental, long-term care, and behavioral health care. Expanded Medicaid eligibility under the ACA uses new MAGI rules for income which eliminate the asset test for non-ABD and eliminate disregarded income types by increasing the MAGI FPL to 308%. This increase in coverage helps families whose income fall into the 300-308% range that did not have income which could be disregarded.

CSHNP, Hawaii District FSHD Coordinator, HMSA, medical provider, and West Hawaii Keiki Health Clinic collaborated to expand access of the CSHNP funded cardiac clinic services to the wider pediatric community. The CSHNP Kauai Cardiac Clinic was discontinued and patients transferred to a cardiologist at Kauai Medical Clinic. These actions resulted in greater access for non-CSHNP children and shifted reimbursements from CSHNP to insurance plans.

CSHNP funded neurology, genetic and nutrition clinics on the Big Island, Kauai, and cardiac, genetic and nutrition clinics on Maui. CSHNP coordinated and managed these specialty clinics and collaborated with community providers.

Early Intervention (EI) services for QUEST (Medicaid)-eligible children are in part reimbursed under a Memorandum of Agreement (MOA) between the Department of Human Services (DHS) and DOH. EI services provided a full array of therapies, interventions, and services to address five areas of development; communication, cognitive development, physical, social/emotional, and adaptive skills.

The Hoʻopaʻa Project, the Hawaii Autism Spectrum Disorders (ASD) State Implementation Grant, helped to develop a framework for integrated service planning and quality monitoring for Medicaid funded program services, with strategies focused on maximizing existing benefits. The Hoʻopaʻa Project provided workshops to train and educate families on the legislative process and insurance issues related to autism spectrum disorder.

CSHNP, Lifetime of Smiles parent support group, Hawaii Pacific Health and community stakeholders collaborated to address a medical insurance disparity for medically necessary orthodontic treatments for orofacial birth defects such as cleft lip and palate. Tricare and Medicaid were already providing this specific medical benefit whereas private medical plans did not.

During the 2014 legislative session, House Bill (HB) 2522 was introduced through private/public collaboration. This

bill would have required private medical insurance plans cover the high cost out-of-pocket expenses for medically necessary orthodontic treatments for children with orofacial birth defects. The bill did not advance. However, the legislature did pass House Concurrent Resolution, HCR 100. It required the State Auditor's Office to conduct a study of the social and financial effects of requiring private health plans cover medically necessary orthodontic treatment of orofacial birth defects.

In September 2014, the Hawaii State Auditor's Report, No. 14-08, recommended HB 2522 be enacted since coverage would provide a substantial social benefit in exchange for a minimal cost to private insurers due to the small portion of the general population affected. Based on the State Auditor's recommendation advocates organized to support the legislation in 2015.

The Genetics program with the HRSA funded multi-state Western States Genetic Services Collaborative (WSGSC) and national efforts continued to work on issues to improve coverage for medical foods/formulas for children with metabolic conditions. This past year, the WSGSC has started a pilot project to help medical directors of state Medicaid agencies and private third party payers to assess the necessity of genetic services and testing. The medical directors can submit cases to an objective expert panel which reviews the case and provides expert opinion about the requested services to help the medical director make the coverage decision. The Genetics program also continues to work with third party insurers to improve reimbursement for telehealth genetic consultations and newborn screening services.

NPM 5: Percent of children with special health care needs age 0 to 18 whose families report the community-based service system are organized so they can use them easily.

Data from the National Survey of CSHCN indicates that 75.1% of Hawaii CSHN can access community based services compared to 65.1% nationally. Children with Special Health Needs Branch (CSHNB) programs work toward coordinated, family-centered services/systems:

- Early Intervention Section is the lead for Part C of Individuals with Disabilities Education Act (IDEA) for early intervention (EI) services for children age 0-3 years with or at biological risk for developmental delays. The EI system includes central directory, public awareness, child find, evaluation/assessment procedures, Individual Family Support Plan, personnel development, procedural safeguards, complaint resolution, financial policies, and data collection.

- Newborn Hearing Screening Program is responsible for the statewide system of newborn hearing screening, including diagnostic audiological evaluation and link to EI services, technical assistance, quality assurance, data/tracking, and education.

- Newborn Metabolic Screening Program is responsible for the statewide system of newborn metabolic screening, including diagnosis and intervention/follow-up, data/tracking, quality assurance, and education.

- Children with Special Health Needs Program (CSHNP) provides medical specialty, nutrition, social work, neighbor island (NI) clinics, outreach for Supplemental Security Income, and other services as a safety net and to increase access to services.

- Genetics Program and state/community partners work to assure the availability and accessibility of quality genetic services in the state. The Program with the WSGSC developed a Portable Health Record for use by people with genetic/metabolic conditions in times of transition or emergencies to improve access to genetic services.

Hawaii Community Genetics, a partnership of CSHNB Genetics Program, Kapiolani Medical Center, Queen's Medical Center, and UH School of Medicine/Pediatrics, provides clinical genetic/metabolic services, clinics, and telehealth visits. Activities to improve access to genetic services for neighbor island families continue through WSCSC projects and evaluation of approaches utilized.

Neurotrauma Supports, in DOH/Developmental Disabilities Division, addresses needs of brain-injured persons and their families. CSHNB is a member of the State Traumatic Brain Injury Advisory Board.
Family Health Services Division (FHSD) coordinates the Fetal Alcohol Spectrum Disorder (FASD) Task Force for development of a comprehensive statewide system for prevention, identification, surveillance, and treatment of FASD. Training is provided for community providers and programs.
CSHNP participates on the multidisciplinary team for the Kapiolani Medical Center's Cleft and Craniofacial Center by providing service coordination for families to identify needs/resources, providing referrals to community programs, and accessing specialized dental/orthodontic treatment services. Team members include craniofacial surgeon, neonatologist/pediatrician, geneticist, genetic counselor, audiologist, speech therapist, pediatric dentist, oral surgeon, orthodontist, and other specialists.
CSHNP Audiologist is a member of Senator Suzanne Chun Oakland's Deaf and Blind Task Force. A bill was introduced to mandate insurance companies to cover hearing aid purchases but did not pass.
CSHNP leads the Vision Screening Task Force that is setting statewide vision screening protocols. Team members include DOH, DOE, doctors and community organizations. CSHNP partners with community organizations like the Hawaii Lions Foundation to help uninsured/underinsured children get access to hearing/vision services, and with Special Olympics Hawaii and Developmental Disabilities Division to ensure that Summer Games athletes have access to medical care.
CSHNP Social Worker participates in the Hiilei Program. Children age 0-5 who do not qualify for EI services are periodically monitored using the Ages and Stages Questionnaire.
The issues of early childhood development/screening and transition to adult health care were selected as state Title V priorities. Two Title V Workgroups focus on system-building to develop resources, provide information, and incorporate the issues in state planning and policy initiatives.
Ho'opa'a Project–Hawaii Autism Spectrum Disorder (ASD) State Implementation Grant is a collaboration of **Hawai**i Pediatric Association Research and Education Foundation with Hilopa'a, Family Voices of Hawaii, DOH/CSHNB, AAP-Hawaii Chapter, and UH Department of Pediatrics/MCH Leadership Education in Neurodevelopmental and Related Disabilities (LEND) (Sept. 2010-Aug. 2013). Project activities focus on improving/strengthening the system of care for children/youth with ASD and other developmental disabilities in areas of family support, medical home, autism screening, insurance coverage, and information/training on evidence-based practices, community resources, and transition.
With the Hawaii District Office FHSD Coordinator, CSHNP expanded access to pediatric cardiology clinic services in West Hawaii, by transitioning the CSHNP cardiac clinic (limited access) to a community health center with wider community access, supported in part by health insurance. This helped increase access to specialty care and related services.

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

SPM 9: The percentage of youth with special health care needs, 12-17 years of age who received all needed anticipatory guidance for transition to adult health care.

The foundation for transition begins in early childhood. The DOH CSHNB EIS instills the importance of transition planning and support for children with developmental delays from the initial meeting. Data from the National Survey of CSHCN 2009/2010 show that 37.3% of Hawaii CSHN received transition services compared to 40% nationally. The National Survey also indicated that 34.5% of YSHCN, 12-17 years of age who received anticipatory guidance for transition to adult health care compared to 31.6% nationally. Hawaii selected a measure that best reflects the current focus of program efforts to improve transition services.
CSHNB staff continued to offer outreach services including transition information to medically eligible SSI applicants 16 years old and younger, and other families. CSHNB Chief presented on the needs of YSHCN/families to physicians involved in designing adolescent health strategies for Hawaii Medical Services Association (HMSA).

Title V Transition Workgroup and a Hilopa`a parent participated in the joint Family Voices and National Initiative for Children's Healthcare Quality webinar, "The ABC's of QI". These interactive sessions explained some of the art and science behind QI using PDSA-Plan, Do, Study, Act cycle steps.

Homework included identifying an aim statement and measurements, doing small scale testing, and studying the results. PDSA tools will be used in future planning efforts.

The Title V Transition Workgroup developed an eye-appealing 'Footsteps to Transition' handout. Based on the Hilopa'a Transition Workbook, this one-pager identifies key transition activities for families and/or providers. It is an educational tool shared as part of client services and at public events and presentations. An additional handout, "The Student Disability Services in Higher Education" was developed by the workgroup listing of university, community college, and adult education program contact information. The handout is updated regularly. These tools may be used with the general adolescent population, with some modification.

Following Maui's Big MAC Transition Fair's footsteps, the islands of Kauai, Oahu, and Hawaii hosted similar events for youth and their families. Presentations were conducted by local and national experts, youth panel speakers and agency/program exhibits to help youth and families access transition services. All families received a Hilopa`a Transition Workbook and Personal Health Record (PHR).

The events are conducted in partnership with the DOE, Title V, Hilopa'a F2FIC, the Arc, Special Parent Information Network (SPIN), the Children's Community Councils, DOH Developmental Disabilities Division (DDD), Department of Health and Human Services Vocational Rehabilitation program, Disability and Communication Access Board (DCAB) and other agencies. The DOE have become strong supporters of the events providing the venue, security, and staffing as well as promoting the fairs to DOE staff and YSHCN.

Building on the success of the school health fairs, Kauai CSHNP received a $2500 Hawaii State Rural Health Association grant for a series of Transition to Adulthood education sessions targeting 16-17 year old special need youth, their parents/caregiver, and service providers. The sessions were held in the evenings to accommodate parents/caregivers. Dinner was provided. Over the six sessions participants were provided information on:

- medical health care needs such as establishing a medical home, other specialist providers and obtaining medical insurance to enable YSHN to be more empowered about their own health care, and
- post high school preparation (alternatives such as college, trade school or vocation training, employment, programs that supportive services, living independent) to promote greater independence.

Thirteen families and 18 YSHCN participated. Evaluations indicate the sessions were very helpful for the families and youth as well as the 12 agencies represented. Plans are being developed to offer future sessions.

CSHNP participates in the annual SPIN Conference, sharing information about transition planning and services. Roughly, 500 families attend this major event. This interactive display includes a "Wheel of Fortune", spin the wheel game comprised of transition topics/questions that family/youth "contestants" have to answer. Small prizes given.

CSHNP staff worked with the Kona Kardiac Kids support group on the island of Hawaii to educate them about transition planning. The group arranged for older peers experienced with transition challenges to work with younger group members for mentoring and support. Neighbor island CSHNP staff in Hilo also integrated transition information and resources for families as part of their "Malama Da Mind" fair. Malama means to protect/care for in Hawaiian.

State Action Plan Table

Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Improve the oral health of children and pregnant women.	• By July 2020, increase the percent of children, ages 1 through 17 who had a preventive dental visit in the past year to 87% (Baseline: 2011-2012 NSCH data 83.1%) • By July 2020, increase the percent of women who had a dental cleaning during pregnancy to 39% (Baseline: 2011 PRAMS data 37%)	• 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	Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months Percent of children in excellent or very good health	A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year		
Improve access to services through telehealth	To be determined	To be determined				

Cross-Cutting/Life Course

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

Preliminary 5-Year Plan: Oral Health

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

Priority: Improve the oral health of children ages 0-18 years and pregnant women
The state priority is based on the Title V block grant guidance National Performance Measures for oral health which focuses on both children and pregnant women. In the previous 5-Year project period oral health for children was identified as a Title V priority, so this is a continuing priority issue for children. The focus on oral health of pregnant women is a new priority for Hawaii.

Objectives:

- By July 2020, increase the percent of children, ages 1 through 17 who had a preventive dental visit in the past year to 87% (Baseline: 2011-2012 NSCH data 83.1%)
- By July 2020, increase the percent of women who had a dental cleaning during pregnancy to 39% (Baseline: 2011 PRAMS data 37%)

The preliminary 5-year plan objectives were developed using the Title V website data from the National Survey of Children's Health and the Pregnancy Risk Assessment Monitoring data as a baseline and projecting a five percent improvement over the next five years.

National Performance Measures:

A. Percent of women who had a dental visit during pregnancy, and
B. Percent of children, ages 1 through 17 who had a preventive dental visit in the past year.

5-Year Strategies

- Develop program leadership and staff capacity
- Develop or enhance oral health surveillance
- Assess facilitators/barriers to advancing oral health
- Develop and coordinate partnerships with a focus on prevention interventions
- Develop plans for state oral health programs and activities

Strategy Development

The five strategies are extracted from FHSD's 5-Year CDC oral health state infrastructure building grant which ends in August 2018. To assure regular feedback/input, oral health stakeholders have been routinely informed about the grant through press releases, presentations/reports at meetings, email updates, conferences, workshops, and legislative hearings. FHSD is working with the DOH Communications Officer to develop an oral health email newsletter. A prototype newsletter has been completed and will be sent to the state oral health Task Force with a survey to collect feedback on preferences for communication/meeting methods, frequency and topics.

Plans for Application Year Federal Fiscal Year 2016 (10/1/15-9/30/16)

- Hiring and conducting leadership orientation for the Dental Director and Program Manager to assure state public health leadership for the state oral health program.
- Complete the third grade oral health basic screening survey, publish final report and disseminate to stakeholders.
- Pilot school dental sealant project (evidence based strategy) to identify cost-effective, sustainable service delivery/financing models.
- Evaluate pilot oral health co-location project at WIC and develop plans to expand to other WIC clinic locations
- Integrate oral health promotion for both women and children into WIC services
- Continue to promote and monitor pediatric providers' application of FV in young children.
- Promote coalition-building, partnerships to assure a diverse/broad participation in efforts state oral health planning.

FHSD was able to fill a half-time office assistant position, but is still recruiting for the Dental Director and Program Manager positions. The exempt Program Manager position is being funded for one year by the CDC PHHSBG grant administered by the DOH OPPPD. The position was established in April 2015. The tentative plan is to deploy the position to FHSD to manage the pilot sealant project and serve as Program Manager for the DOH oral health program. The CDC oral health grant will be used to fund the position once PHHSBG funds expire. Interviews for both

positions are in the process of being scheduled.
Once the positions are filled ASTDD will be providing orientation and training of the new Dental Director and Program Manager. An established distance learning and on site technical assistance will be provided. In addition ASTDD also has a mentoring program where new state dental directors can be paired with an experienced director in another state for a year.
The third grade oral health screening project completed data collection in May 2015. Data entry is planned through June 2015. Data analysis and the writing of the final report will be done by ASTDD by October 2015. The results will be disseminated to agencies, key stakeholder organizations, policymakers, and through media release. The data should help to inform policy and planning decisions including the State oral health task force convened by the Hawaii Healthcare Project Office, to implement a second year CMS State Innovation Model (SIMS) grant. One of the SIM focus area is oral health. The DOH Deputy Director is a co-leader for the oral health task force.
A funding proposal for the pilot school dental sealant project was submitted to the Hawaii Dental Service Foundation (Delta Dental affiliate) and was recently awarded in April 2015. DOH will partner with an existing FQHC dental program to identify a cost-effective, sustainable service delivery and financing models. DOH will work with Medicaid to implement federal policies allowing reimbursement for oral health services delivered in public health settings including schools. OPPPD is also using PHHSBG funds to document the two ongoing school based oral health programs. TA for the project is being provided by a number of national organizations working to promote this evidence based approach to promote oral health prevention to at-risk children (CDC, Children's Dental Health Project, School Based Health Alliance).
The project to improve the oral health of pregnant women will target WIC clients. FHSD is contracting with the University of Hawaii, School of Nursing and Dental Hygiene (SONDH) to evaluate the WIC oral health "*Keiki Smiles*" program and develop recommendations to expand the program to other WIC locations. WIC clients will also be surveyed to identify common barriers to oral health care. The SONDH will explore how the program can extend oral health care to pregnant/post-partum women and conduct workforce training to support oral health promotion in the WIC program statewide.
In 2015, AAP partnered with Hawaii Dental Association to conduct FV trainings for pediatric providers. Website resources were developed and are accessible to providers. An additional training was requested and provided for Family Practitioners. Evaluations of the trainings and information from provider surveys is being compiled and analyzed. Medicaid EPSDT data will also be monitored to assess progress and inform future planning for this recommended evidence based practice. The trainings and website development was funded using the DOH CDC oral health grant.
FHSD will continue to support partnership development and coalition building to assist with development and implementation of project actives. FHSD will draw upon this broad base of partners to help plan and conduct state oral health planning efforts later in the CDC grant project period. To help inform the planning process, FHSD is first working to complete data surveillance and assessment reports (including the environment scan and policy review).

Factors Contributing to Success

Strong public health leadership is critical to guide planning and assure progress with the CDC Oral Health Disease Prevention grant. The acting Dental Director, a non-dental professional, was trained in public health administration and served as the former manager of the state chronic disease program, thus she was extremely knowledgeable/experienced regarding the public health approach to program development and problem solving. ASTDD content expertise, technical assistance, orientation was critical to guiding planning, implementation, and achieving CDC grant benchmarks and requirements.
Locating the oral health program in the MCH agency, with a culture of working in collaboration and partnership, helped facilitate:

- teamwork among a diverse group of staff,
- working with internal/external partners and
- leveraging resources.

The MCH agency also provided access to extensive resources including MCH epidemiology staff, Office of Primary Care and Rural Health, as well as a number of federal HRSA grant resources.
Additional assets that have helped drive progress include:

- many dedicated oral health stakeholders and community-based programs,
- strong legislative and administrative support for oral health as a priority, and
- substantial national technical assistance and resource availability.

Challenges, Barriers

While Hawaii has many dedicated oral health assets, a major challenge is the lack of oral health infrastructure to develop a coordinated system of care. Unlike most states, Hawaii has no local health departments, thus DOH is key in providing statewide leadership for critical public health surveillance, evaluation, planning, and prevention functions. With no dental school in Hawaii, DOH 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. The state also lacks a current strategic oral health plan; the last plan is nearly 10 years old.
The primary barrier to achieving greater progress are the vacant oral health positions (Dental Director and Program Manager) which are essential to provide dedicated public health leadership and staffing for the DOH oral health program. A protracted personnel process required almost a year to establish the positions. The election of a new Governor and resulting administrative changes in the DOH has also impacted the program efforts. The acting State Dental Director and FHSD Chief, who also serves as the grant Principal Investigator (PI); was appointed to be the Deputy Director in the DOH. While she continues to serve as State Dental Director and grant PI, her areas of responsibility have significantly expanded resulting in less time to focus on the immediate needs of the grant. This has contributed to further delays in the grant progress.
FHSD has also been hampered by loss of key administrative and management positions. The unexpected death of the Division chief administrative officer and untimely injury to his secretary (which required her to be on sick leave for several months) has also created additional work for an already overburdened staff.

Completing 5-Year Action Plan Activities

FHSD will continue to work on the current administrative and project activities discussed above. An update on progress will be provided in next year's Title V report. Any needed changes to the preliminary 5-Year Plan will be made. Based upon guidance provided by AMCHP and the federal MCH Bureau, performance measures will be identified for evidence based practices.

New State Priority: Improve to Services through Telehealth

A state performance measure will be established for this new priority. 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 time and money.
The legislature is supportive of telehealth as evidenced by the passage of Act 159 (2014) which mandated reimbursement parity for face-to-face and telehealth visits provided by health care providers. Health care providers are defined as primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians, advanced practice registered nurses, psychologists, and dentists.
The Title V Genetics Program currently works to increase access to genetic services on the Neighbor Islands, with genetic consultations done with in-person clinics or using telehealth via videoconferencing. Satisfaction surveys of neighbor island families receiving genetic services and counseling via live videoconferencing show a very high acceptance and satisfaction with the services provided. Twenty percent of the families reported that they would not have sought genetic services for their child if telehealth had not been an option. Although the Genetics program is effectively using telehealth, Title V programs/activities are generally not using the technology for service delivery to clients
Title V is also supporting the use of telehealth resources for healthcare provider training. The State Office of Rural Health is supporting Project ECHO. Part of a national telehealth training network, Project ECHO links expert specialist teams at an academic hub with primary care clinicians in local communities. Primary care clinicians,

particularly on the neighbor islands, will participate in a learning community, receiving mentoring and feedback from specialists. Together, patient cases will be managed to assure needed care is provided.
Plans include:

- Inventory of telehealth sites and equipment available to Title V programs.
- Continue and expand provision of genetic services via telehealth to the neighbor islands.
- Implement and expand Project ECHO (Extension for Community Healthcare Outcomes), using a tele-education model, to Title V programs and other partners
- Collaborate with University of Hawaii Telecommunications and Social Informatics Research Program, State Telehealth Access Network, and the Pacific Basin Telehealth Resource Center to plan, develop, implement, and evaluate telehealth activities used by Title V programs.
- Develop a telehealth training and mentoring program to increase the workforce knowledge and use of telehealth for their activities.
- Collaborate with other local, regional and national maternal and child health partners to support policies and activities to increase the use of telehealth for families and providers.

Completing 5-Year Action Plan Activities
FHSD will select a state performance measure for this priority next year. Work will continue on the project activities discussed above and an update on progress will be provided in next year's Title V report. Any needed changes to the preliminary 5-Year Plan will be made. Based upon guidance provided by AMCHP and the federal MCH Bureau, performance measures will be identified for evidence based practices.

Cross-Cutting/Life Course - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.0	45.0	45.0	45.0	45.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	87.0	87.0	87.0	87.0	87.0

For the Cross-Cutting/Life Course population domain Hawaii is reporting on the national and state performance measures which address the following issues:

- NPM 9: Dental Sealants
- SPM 10 Youth Oral Health Visits.

NPM9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
The 2014 data indicates 11.8% of 6-9 year children enrolled in the Medicaid EPSDT program received sealants; the objective of 12% was nearly met. At this time the state does not have population based data for this measure. The

sealant placement rate has remained low for this high risk group, far below the HP 2020 objective of 25.5%. Data from the state's largest commercial dental insurer, Hawaii Dental Service (HDS) reported 28.8% of high risk 6 & 7 year olds (having one or more restorations in the past two years) and 19.9% of low risk children receive sealants. Thus, children with private insurance are also not receiving sealants as a preventive practice. With no civilian fluoridated water systems in Hawaii, dental sealants are an important preventive intervention.

See narrative for SPM 10 under "Cross-cutting/Life Course" domain for report on dental activities.

SPM 10: Proportion of public high school students who received dental care in the past year.

The 2013 Youth Behavioral Risk Survey (YRBS) data indicates 70.3% of students reported seeing a dentist in the past year. FHSD sponsored the addition of an oral health question in the YRBS after consultation with stakeholders and the MCH Bureau to provide a more consistent, reliable data source for the measure. The addition of these core question options will generate national comparative data for future work and research.

In 2009 the DOH dental health program was eliminated as part of the state budget cuts. Three years later, in 2012, the Title V agency was assigned the responsibility for rebuilding the DOH oral health infrastructure including surveillance, planning and prevention functions. In lieu of an oral health professional to lead the program, FHSD works in consultation with the DOH Developmental Disabilities Divisions (DDD) dentist and utilizes technical assistance from the Association of State & Territorial Dental Directors (ASTDD). The DDD operates dental clinics on Oahu and at the Hawaii State Hospital serving largely adults with disabilities.

Oral health is particularly important since Hawaii's long standing last place state ranking for accessibility to fluoridated water systems. The only fluoridated water systems are located on military bases and housing. Strong public sentiment has persisted over the past fifteen years against efforts to adding fluoride to Hawaii's public water systems.

To help build the state oral health program, FHSD applied for and received a 5-year CDC state oral health infrastructure building grant in 2013. The grant funds will go largely to funding a dental director position to provide leadership for the program. The seven grant goals includes hiring/training of dental program leadership, establishment of surveillance system, support coalition building and partnership development, completing an environmental scan of barriers/facilitators, building of evaluation capacity, development of a state oral health plan, and communications plan. The goals were designed to support a "collective impact" approach to oral health improvement.

With no dedicated oral health staff, FHSD convened a collaborative team led by the FHSD Division Chief and comprised of staff from the Office of Primary Care and Rural Health, the Title V Division Planner, and the CDC-deployed MCH Epidemiologist to develop the application and manage the grant until positions could be established and filled. This unique partnership among the HRSA grantees was recognized in the National Organization of State Offices of Rural Health newsletter. Additional support was provided by FHSD neighbor island nurses, part-time pediatric Medical Director who also serves as the American Academy of Pediatrics (AAP)-Hawaii Chapter Oral Health Champion, and a Council of State and Territorial Epidemiologists (CSTE) MCH Epidemiology Fellow. Key assistance for Hawaii's CDC grant application was also provided by local and national oral health partners.

In 2014, the grant staff positions were established and posted on the DOH website and various professional listings at the state and national levels. Recruitment continues. In the meantime, FHSD has been able to leverage the CDC grant salary savings funds to initiate a number of infrastructure building projects and establish important partnerships to help expand the program's resources and capacity.

An oral health data surveillance plan as well as three evaluation plans were developed with technical assistance (TA) from ASTDD. An Oral Health Data report is being finalized for posting on the DOH website. The report includes existing data from self-reported survey data (BRFSS, PRAMS, YRBS, National Survey on Children's Health), hospital emergency room data, Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) data, and medical provider data. A Key Findings summary report is scheduled for publication in June 2015.

FHSD contracted with the Hawaii Primary Care Association to conduct a third grade oral health Basic Screening

Survey (BSS), using a representative sample, assessing the oral health status of children. Branded *Hawaii Smiles*, the project completed data collection in May 2015. The sample involves 66 public and charter schools throughout the state on six islands. The survey data will provide county and state-level estimates. Hawaii is one of five remaining states that have not reported BSS data to the CDC National Oral Health Surveillance System (NOHSS).

The Hawaii Dental Service Foundation (the Delta Dental affiliate and Medicaid third party administrator for oral health) provided an additional $137,000 for the BSS. FHSD was also able to leverage funds from two federal DOH grants for the BSS: HRSA State Systems Development Initiative (SSDI) and CDC Preventive Health and Health Services Block grant (PHHSBG). The latter is administered by the DOH Office of Planning, Policy and Program Development (OPPPD).

The project reflects the success of FHSD to leverage its partnerships. In addition to the partners mentioned the project included the full support of the Department of Education (from the state superintendent, Central Office staff, District superintendents, principals, student health aides, and parent volunteers); DOH Public Health Nursing, all three District Health Offices, Immunization Branch, Hawaii Dental Association, Hawaii Dental Hygiene Association, FQHC dental programs, Lutheran Medical Center Pediatric Dental Residency Program, and Hawaii's Medical Service Corp.

In 2014, the DOH hosted an oral health data workshop with Iowa Dental Health Director, Dr. Bob Russell. The participants identified state oral health data needs. Participants representing the Hawaii Dental Association, Hawaii Dental Service, Public Health Nursing, the University of Hawaii School of Nursing and Dental Hygiene, dental staff from Federally Qualified Health Centers (FQHC), and WIC meet quarterly to follow up on recommendations from the workshop. The group has also provided input on data publications and other DOH projects. While in the islands, Dr. Russell presented the keynote talk at the State Primary Care Conference. Grant funds were used to sponsor an oral health track at the conference.

In an effort to complete the state environmental scan of oral health facilitators/barriers, FHSD contracted with the Children's Dental Health Project (CDHP) to complete a policy review of oral health legislation passed over the past eight years. The review, along with the data publications, is intended to inform a future policy consensus planning process. FHSD also contracted a local dental professional to complete a program profile of key state oral health programs, services, and resources.

FHSD in partnership with the OPPPD, an initial plan was developed for a pilot school based dental sealant program. The project is a result of work conducted under an Aspen Institute for Excellence in Public Health Law Award begun in 2013 which DOH used to examine oral health policies in the state. To support the project, OPPPD is supporting the hiring and funding of a program manager position in the CDC PHHSBG grant.

FHSD contracted with the American Academy of Pediatrics (AAP)-Hawaii Chapter to conduct fluoride varnish (FV) training with pediatric providers and develop website resources. The trainings were designed to promote the 2014 Hawaii Medicaid policy decision to reimburse pediatric providers to apply fluoride varnish for young children. The Medicaid policy was adopted after six years of advocacy by AAP-HI Chapter. FV has been found to be effective in preventing cavities for children 3-5 years. New recommendations released in 2014 from the US Preventive Services Task Force, AAP, and American Dental Association recommends FV in the primary care setting every 3–6 months starting at tooth emergence.

Oral Health Activities in FHSD Programs

WIC educates clients on baby bottle tooth decay, caries prevention and the importance of the dental home and regular oral care. The Kona WIC office provides space and makes appointments for a dentist and dental hygienist with the West Hawaii Community Health Center (WHCHC) Oral health exams, fluoride varnish, and education is provided to children and their parents. Referrals are made to assure follow-up care and establish a dental home.

Title V's Children with Special Health Needs Program (CSHNP) provides case management for children with craniofacial conditions and partners with the multidisciplinary craniofacial center at the children's hospital in Hawaii to address access issues or gaps in dental services. CSHNP also provides limited financial assistance for

orthodontic treatment and provides assistance to other families enrolled in HMO plans.
The Title V Primary Care Office (PCO) provides state dental health subsides to 13 FQHC for treatment services (no preventive services), and establishes/updates federal dental health shortage area designations. Of the 14 FQHC, 13 provide dental services. The PCO also supports the recruitment and retention of oral health professionals to practice in underserved areas. Services for the uninsured are available on all the major islands through the FQHCs or through partnerships with dental providers. FQHCs are able to expand their services by utilizing dental residents. Two FQHCs enabled greater access to oral health care through mobile dental services and two FQHCs on Oahu have school dental sealant programs.
The neighbor island counties have oral health coalitions where access to dental services is more challenging since most dentists practice on Oahu. The FHSD neighbor island nurses play critical convener/facilitator roles for the coalitions. The Hawaii Primary Care Association (HPCA) and FHSD convenes the meetings of the State Hawaii Island Oral Health Task Force (HIOHTF) to share information and identify collaborative strategies.
Through its home visiting programs for at-risk families with children 0-3 years old, the Maternal and Child Health Branch is partnering with the AAP-Hawaii on a project to train home visitor staff on oral health education for families.

Other Programmatic Activities

GENOMICS SECTION was reorganized in November 2012 and continues to be extensively involved in planning, coordinating, implementing, and evaluating statewide activities to improve access to genetic, newborn screening, and birth defect services and education. This includes providing genetics, newborn screening, and birth defects education to health care providers, public health staff, and students; maintaining newsletters and several websites; supporting Hawaii Community Genetics for clinical services; establishing Neighbor Island genetics services (in-person outreach and telehealth clinics); and working with the Newborn Metabolic Screening Program on current issues such as expansion of disorder panel, quality improvement activities and retention of residual dried blood spots.
The Genomics Section is the grantee of one of the seven Health Resources and Services Administration funded Regional Genetics networks, the Western States Genetic Services Collaborative (WSGSC). This Collaborative covers Alaska, California, Hawaii, Idaho, Oregon, Washington, and Guam and seeks to improve genetics and newborn screening assessment, services, and education. One of the well-received activities of the WSGSC is the newborn screening parent fact sheets. The fact sheet website (www.newbornscreening.info) receives almost 300,000 unique visitors per year. Another growing initiative is the website resource http://www.westernstatesgenetics.org/ACA_home.htm) to help families and healthcare providers find information about the Affordable Care Act (ACA). The resource uses the concept of HRSA's life course approach combined with Milton Bradley's "Game of Life" to help families navigate to the information they want about the ACA. Also, as part of this project, the Genomics Section continues to work with Guam to develop a comprehensive newborn screening follow-up program.
HAWAII BIRTH DEFECTS PROGRAM (HBDP) is a population-based active surveillance system for birth defects and other adverse pregnancy outcomes that was established in 1988. It annually finds and collects demographic, diagnostic, and health risk information on 800 to 1,000 infants diagnosed with a birth defect. Data are analyzed for incidence, trends, and clustering, which contribute to the identification of genetic, environmental hazards, and other causes or risk factors. HBDP is funded from $10 of each marriage license fee which goes into a special fund. HBDP was established as a DOH program by the 2002 State Legislature (H.R.S. SS321-421).
DOMESTIC VIOLENCE FATALITY REVIEW The Maternal and Child Health Branch has implemented a Domestic Violence Fatality Review which is a legislative initiative intended to reduce the incidence of preventable deaths related to domestic violence. The DOH is the lead agency to administer statewide team reviews and through this process the MCHB is collaborating with key agencies involved in Domestic Violence. The hope is that through this collaboration the MCHB can participate in advocacy efforts improve the systems of care and interventions related to intimate partner violence.

DOMESTIC VIOLENCE.SEXUAL ASSAULT SPECIAL FUND AND SEXUAL VIOLENCE/RAPE PREVENTION AND EDUCATION The Maternal and Child Health Branch receives funding through a Centers for Disease Control Grant to address Sexual Violence Prevention. The Rape Prevention Education grant provides needed primary prevention dollars to address this critical public health issue. The Maternal and Child Health Branch also oversees the Domestic Violence and Sexual Assault Special Fund established by the legislature. This fund and the programs related to domestic violence/intimate partner violence and sexual violence prevention provides opportunity for the MCHB to expand its efforts toward violence prevention statewide. The Branch is looking at ways to expand the surveillance capacity in these areas and ways to collaborate with other women's health initiatives within the branch, such as family planning and the perinatal programs to assure that women are screened and able to access violence prevention information and services as needed through these service delivery points. As state funding and staffing diminish, the branch continues to find ways to coordinate and collaborate across MCHB programs and integrate violence prevention strategies where there are shared outcomes.

THE OFFICE OF PRIMARY CARE AND RURAL HEALTH (OPCRH) is composed of three programs, the State Office of Rural Health (SORH), the Medicare Rural Hospital Flexibility Program (FLEX), and the Primary Care Office PCO). The overall goals of the programs to coordinate federal, state, and local efforts aimed at improving the health of Hawaii's rural and medically underserved populations.

The **STATE OFFICE OF RURAL HEALTH SORH** administers the HRSA Rural Communities Healthcare Infrastructure Transformation (RCHIT) grant that provides technical assistance to meet rural community health needs coordinates rural health resources and activities statewide in collaboration with other public and private organizations, and plan, organize, coordinate, implement, and evaluate rural health projects, particularly those that build capacity in rural communities. The SORH was instrumental in supporting the development and distribution of two successful documentaries based on the social determinants of health. The first film, Ola, 'Health is Everything', is about health, hope and the power of communities to heal themselves. The sequel - *'Ike: Knowledge is Everywhere* - explores the challenges of the education system in Hawaii and, in the spirit of the first documentary, offers solutions to those challenges by showcasing the inspiring work of community leaders. A very recent effort will be bringing the Project ECHO to the islands. Project ECHO links expert specialist teams at an academic hub with primary care clinicians in local communities. Primary care clinicians, the spokes in our model, become part of a learning community, where they receive mentoring and feedback from specialists. Together, they manage patient cases so that patients get the care they need.

The **MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM (FLEX)** and the **SMALL RURAL HOSPITAL IMPROVEMENT PROGRAM** (both HRSA funded) work closely with rural health hospitals and in particular Critical Access Hospitals (CAH) addressing quality-of-care issues, improving the financial, operational, and clinical performance of rural hospitals, developing and implementing rural health networks, and educating and providing technical assistance to rural facilities on the implementation of electronic health records, health information exchange, and other health information technology. The FLEX program plans and conducts quarterly meetings of all CAHs. These meetings serve as an important venue for training and technical assistance regarding financial and organizational performance. In 2014, the FLEX office sponsored and provided comprehensive technical assistance with five CAHs to conduct community needs assessments. The results of the assessment included a list of needs, prioritization of the needs, and listing of possible strategies and responsible organizations to meet the needs.

The **PRIMARY CARE OFFICE** (PCO) administers the HRSA-funded Primary Care Services Coordination and Development grant to improve primary care service delivery and workforce availability in the State to meets the needs of underserved populations. The PCO is responsible for researching and developing new federal Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Populations (MUA/P) as well as renewing

current designations based on need. HPSAs are used by over 20 federal programs including the CMS Physician Bonus Payment, HRSA training grants, and Medicare Incentive Program. The PCO also serves as the state point of contact and resource for the federal financial loan and scholarship programs under the National Health Service Corps. Technical assistance and training is provided to community organizations and individuals working in the recruitment and retention of health care providers across the state. Key partners in these efforts include the Hawaii Primary Care Association, Hawaii's 14 Federally Qualified Health Centers, and the health professional schools in the islands.

II.F.2 MCH Workforce Development and Capacity

The needs assessment identified several critical areas concerning the MCH workforce and capacity. A substantial portion of the MCH Title V agency capacity has been lost since 2009 due to the reduction in force (77 permanent positions eliminated, 20% of workforce) and elimination of several state funded programs for children, including the MCH Branch Child Wellness Section. These RIFs also precipitated a number of retirements resulting in the loss of MCH expertise within the agency. FHSD was further crippled when RIF'd employees from other state agencies were placed into vacant FHSD positions or "bumped" junior employees from their positions. Most of these employees did not have the skills or expertise for these positions.

Over the past six years, the strain on the Title V agency has only magnified. Additional positions were eliminated or have been left vacant due to funding shortfalls. Workloads for remaining staff have increased substantially. For those positions which FHSD is allowed to fill, significant barriers remain in hiring qualified candidates.

In 2015, the Title V agency suffered an additional setback with the loss of key leadership positions due to the election of a new Governor and change in administration. This resulted in the vacancy of the Title V Division Chief position and the MCH Branch Chief. The Branch Chief position has experienced continuous turnover since the 2009 RIFs. While the Title V agency has been able to add staff positions due to new federal grant awards (for home visiting, oral health, and teen pregnancy programs), these positions have a program-specific focus and have not helped to fill critical gaps left by staffing losses over the last six years. In fact, the size and scope of the home visiting grants have added considerable strain to the administrative staff.

Given the crippling impact of these changes, Title V management embarked on a pilot process to re-examine agency operations and identify ways to work "smarter" and more efficiently with remaining resources. The Division was afforded a unique opportunity to work with an organizational consultant, Fresh Leadership. FHSD piloted this strategic operations planning process for the Department of Health (DOH) to determine its value to other DOH programs. With over 300 employees and an annual budget of $90 million, the Family Health Services Division is one of the largest divisions in the DOH (the size of a large corporation) and served as a microcosm of the overall Department. The project was funded by a grant to DOH from the Centers for Disease Control and Prevention for infrastructure building and performance improvement. Through the initial process, the FHSD team identified four core operational issues:

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

One of the first activities resulting from the StratOps process was a Division meeting designed to promote greater collaboration and coordination among FHSD programs. The meeting was held in January 2014 and used a new planning approach compared to Division meetings held in previous years. A planning committee with broad participation from all staffing levels was convened. Family Voices/F2FIC was a vital partner. Meeting attendance was also expanded to be more inclusive of clerical, administrative and neighbor island staff.

The result was a Division meeting that was one of the most fun, successful, well-attended, and well-received meetings. Titled "Mission ImPossible: Promoting Lifelong health and Wellness. The day was used to promote and

highlight the importance of Title V programs and staff to the well-being of families and community health. In addition to standard presentations and updates, activities included a FHSD health fair with displays from all the Title V programs, games to test people's knowledge about the programs, a case study activity to learn how FHSD programs could be used to help an at-risk, pregnant teen; and the final mission for teams was to create a short five minute video presentation/infomercial how FHSD programs serve our families and communities. The videos were shown at the end of the day, showcasing the staffs' creativity, humor, teamwork, and "acting skills". Most importantly, the presentations reflected the knowledge gained from the day's activities.

The meeting also included a poignant tribute to the former DOH and Title V Director, Loretta Fuddy, who was tragically killed in a plane crash the previous month. Staff were given personalized binders to collect information and business cards from each program display to keep as a "resource directory".

The Mission Impossible theme was used creatively from a secret "video" staff invitation to the delivery of the mission for the day from a secret agent, and the final declaration at the days' end of the "Mission Accomplished." The event clearly demonstrated that the Title V workforce is the greatest FHSD asset highlighting staff innovation, expertise, resilience, and dedication.

Another small project which resulted from the StratOps process was the decision to apply for an MCH Workforce Development Technical Assistance opportunity. FHSD was able to use the award to advance system building efforts around the continuing Title V priority on developmental screening. Although only a few early childhood programs participated in the TA, collaboration was improved and new skills and tools to improve quality were gained.

Progress on the StratOps priorities waned when the consultant contract ended in 2014 and other organization priorities took precedent. FHSD found the StratOps approach had limited application to DOH overall since it was tailored primarily for private sector organizations with greater flexibility to streamline operations. Despite these limitations, the experience strengthened the management team and helped to develop a common vision and direction for the Title V agency.

The new Title V guidance, with its greater emphasis on internal resources, workforce development, and capacity building; are being used to reinvigorate efforts in the four operational areas. The Title V leadership team used the new grant guidance to explore different ways of working on the needs assessment and block grant report.

The 2009, Title V assessment utilized staffing time and resources extensively. This time FHSD conducted the needs assessment aware of the climate of "overwhelm" that prevailed in much of the Division. Thus, FHSD strategically used existing resources; integrated the substantial assessment work already conducted by other health-related agencies; used key partnerships; and built upon ongoing programs, plans and strategic initiatives. Using this approach, FHSD was able to reduce duplication of assessment efforts on communities and assured the Title V priorities and plans were well-aligned with important partners in public health and the health care system.

For the development of the annual report, FHSD convened nearly 50 staff from across the state in face-to-face meetings around the population domains to discuss how the Title V programs contribute/address each of the 18 national and 7 state performance measures. The sessions were facilitated with assistance from Family Voices, the F2FIC, and MCH LEND faculty. Participant evaluations of the sessions indicated that staff welcomed the opportunity to learn more about Division programs and identify opportunities for collaboration. Discussion of the performance measures by domain provided an effective framework to share program information.

Title V will use this pilot format to create an in-house leadership institute training program to help advance the Title V state priorities. The meetings will be used as a forum for shared learning, problem solving, and skills building. Participants will help shape the topics, assist with trainings, and share information needed to assure progress on the priorities. Resources from the MCH Workforce Development Center and a MCH Workforce Development Technical Assistance award will be used to develop the curriculum. Modules on quality improvement, systems integration, and leadership development will be reviewed for consideration. Any TA on evidence based/evidence informed strategies and measures will also be shared through meetings. The Title V Epidemiologist and new CSTE MCH fellow will also participate to assure effective use of data. Assistance from F2FIC and MCH LEND faculty will be used to support/facilitate the sessions.

Through the development of the training Institute, FHSD intents to use the training resources to inform the

development and monitoring of the Title V 5-year plan strategies and activities. The program will assure integration and application of science based practices, quality improvement techniques, and systems approaches to effectively improve health outcomes. FHSD will explore a technical assistance request to support this activity.
The Title V agency programs also support a substantial amount of training for the MCH workforce statewide. Several federal grants include workforce development as a key strategy/activity including:

- Maternal Infant Early Childhood Home Visiting grant supports monthly training for the Hawaii Home Visiting Network.
- Early Childhood Comprehensive Systems grant supports training for providers on developmental screening tools and protocols.
- Hawaii Medicare Rural Hospital Flexibility Program grant is used to conduct training on healthcare quality improvement for healthcare professionals and operational and financial performance improvement for Critical Access Hospitals.
- Family Planning shares resources from the National Family Planning Training Centers to local providers via quarterly meetings, webinars, and conference calls.
- The State Office of Rural Health sponsors numerous training projects such as Community Paramedicine training that utilizes paramedics to provide primary care in rural areas.

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

- Fetal Alcohol Spectrum Disorders '101' training conducted for the State Judiciary, Family Court judges.
- Genetics offers webinars on current issues in genetics to providers.
- The Child Abuse and Neglect (CAN) Prevention program conducts presentations on Protective Factors to prevent CAN.
- Primary Care office conducts presentations routinely on loan repayment opportunities to public and private health care/medicine school programs as well as Hawaii Medical Education Council.
- WIC staff conduct breastfeeding training seminars to community providers statewide in partnership with the District Health Offices and the Early Childhood Comprehensive Systems program.
- Neighbor island District Health Offices host monthly conference calls for healthcare professionals during lunch hours for both DOH staff and 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.
- Oral Health track of presentations, keynote speaker for State Primary Care conference.

Neighbor Island District Health Offices also sponsor community forums related to emerging concerns, including reducing substance use during pregnancy. Internally, Children with Special Health Care Needs regularly host speakers at staff meeting on current topics of interest.

II.F.3. Family Consumer Partnership

The Hawaii Title V agency works in partnership with families in numerous settings. The head of Hawaii Family Voices was 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 the Title V priorities.
Family leaders/partners of diverse ethnicities participate on various councils, committees, and collaboratives related to FHSD programs 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

Family leaders also participate as interview panel members for key CSHCN positions.

This year after a three year effort, House Bill 174 (Act 213) became law on July 2, 2015, 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. Title V staff and advocacy partners the HIF2FHIC, and the State Council on Developmental Disabilities, mentored the informal family support group “Lifetime of Smiles” through the legislative process. Through this advocacy effort, family leaders have emerged and now serve in leadership roles such as the Co-Chair for the Hawaii Early Intervention Coordinating Council and the Secretary for the newly incorporated Family Voices of Hawaii non-profit board of directors.

Another example of family partnership/leadership development is being conducted by the FHSD Office of Primary Care and Rural Health (OPCRH). OPCRH is contracting with local family service agencies 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 parents’ capacity as change agents for children. The first cohort “graduated” in 2015, and the next group will begin in fall 2015. The program will expand to include other geographical areas. Graduates were required to attend all 20-week training 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.

II.F.4. Health Reform

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 have encouraged families and individuals served to access the Hawaii Health Connector to enroll for health insurance if needed. The Hawaii Exchange hired a full complement of staff to assist consumers with enrollment.

The Office of Primary Care and Rural Health (OPCRH) was also instrumental in providing support for small rural critical access hospitals (CAH) to complete community health needs assessments (CHNA). Although smaller hospitals were not required to conduct the assessments under ACA, OPCRH helped secure technical assistance (TA), training, and facilitation for community meetings, quantitative and qualitative data collection, and completion of final reports. The OPCRH also provided TA and support to the Healthcare Association of Hawaii (HAH) that represents Hawaii’s large hospitals, as they embarked on their own series of CHNAs. The data and input collected from the CAH CHNAs were incorporated into the HAH’s CHNA. Also, OPCRH and other Title V program staff participated in the CHNA both community and topic focused meetings.

These CHNA meetings brought together diverse stakeholders to brainstorm solutions and commit resources. This represents the start of community conversations and collaborations that will inform the State of Hawaii, Department of Health’s future State Health Improvement Plan.

The community input from the state and CAH CHNAs were incorporated into the Title V needs assessment process to assure broad community input. By utilizing the results of the CHNA process, Title V was able to reduce the burden on communities (to participate in another assessment process) and align Title V priorities with ongoing community

health improvement efforts.
Historically, Hawaii has had a large proportion of its population covered by some form of health insurance because of the 1974 Prepaid Health Care Act. 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 fairly generous set of benefits that must be provided. Thus the Title V agency's primary role in ACA has been working with stakeholders to clarify the expanded benefits under ACA, inform consumers and service providers, and assure access to care.
Under ACA, Hawaii's enrollment success was achieved with Medicaid expansion and coverage for legal adult migrants under the Compact of Free Association (COFA) Pacific Island countries who do not qualify for many federal entitlements. These populations may be unfamiliar with the concept of preventive health care and assuring access to services is a challenge statewide. Four of the eight new Title V national performance measures reflect the focus to assure the MCH population is able to access preventive and wellness services covered under ACA. The new measures address the population domains for women, children, adolescents, and cross-cutting. See the plans for these respective domains for strategies, plans and activities.
Currently, Hawaii has three ACO like organizations:

- Queens Clinically Integrated Provider Network (QCIPN)
- Hawaii Health Partners (HHP)
- Accountable Rural Health Care Alliance of Rural Oahu (AHARO).

In the future FHSD intends to share the new Title V priorities with these organizations to identify opportunities for partnerships. ACOs could, for instance, focus their physician incentives around Title V priority areas especially those related to preventive health/wellness visits.

II.F.5. Emerging Issues

ADVERSE CHILDHOOD EXPERIENCES

Adverse Childhood Experiences (ACEs) is gaining more attention in Hawaii. Addressing ACEs is part of the lifecourse approach to health. ACEs include: socioeconomic hardship, divorce/separation of parents, death of parent, parent served time in jail, witness to domestic violence, victim of neighborhood violence, living with someone who was mentally ill or suicidal, lived with someone with alcohol/drug problem, treated or judged unfairly due to race/ethnicity, and other factors. Studies have shown that ACEs impact children's health and emotional well-being. Children who experience ACEs are more likely to have learning/behavioral issues and poor health outcomes.

Data from the National Survey of Children's Health 2011/12 for children age 0-17 years show that 26.3% Hawaii children have one adverse family experience, and 20.1% have two or more adverse experiences (total 46.4% have at least one adverse experience). This is comparable to nationwide rates.

For Hawaii, groups with greater proportions of children with adverse family experiences include those with lower income and special needs:

- The proportion with two or more adverse experiences was significantly higher for children with lower incomes – 0-99% Federal Poverty Level (FPL) (26.3%) and 100-199% FPL (29.5%), compared with 400 FPL or higher (11.7%).
- The proportion with two or more adverse experiences was significantly higher for children with special health care needs (CSHCN) (37.0%), compared with non-CSHCN (16.7%).
- The proportion with two or more adverse experiences was significantly higher for children with emotional, behavioral, or developmental issues (52.9%), compared with other special health care needs (29.7%) or non-CSHCN (16.7%)

Information on ACEs and early brain development has been presented at various Hawaii conferences and meetings with pediatricians, early childhood community, and Hawaii Zero to Three Court during the past year. Promoting resilience, protective factors, and well-being for children/families can help to ameliorate adverse experiences. In the child health population domain, the FHSD work to prevent child abuse and neglect and to promote early childhood screening and development (with appropriate follow-up) contributes to addressing the issue of ACEs.

Sources: National Survey of Children's Health, 2011/12; American Academy of Pediatrics, "Adverse Childhood Experiences and the Lifelong Consequences of Trauma", 2014.

II.F.6. Public Input

A set of handouts on Title V was developed to share the findings of the needs assessment with stakeholders and to collect public input (see Supporting Documents). The handouts included:

- One-page Fact Sheet describing Title V (including a link to an online survey for input on the Title V priorities)
- Summary table of needs assessment issues, final priorities,and rationale
- Graphic of Title V priorities along the life course

FHSD staff presented information on the Title V needs assessment findings and new priorities at various meetings, including the 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, Community Children's Council Co-Chair meeting with parent and professional co-chairs from all islands, Sequenced Transition to Education in the Public Schools (coalition of public-private agencies/individuals serving the 0-8 year old population) on Maui, and Central Maui Domestic Violence Task Force. Staff also documented comments at presentations.

Generally, comments thus far have expressed appreciation for the sharing of the information and provided validation for the new/ongoing priorities. Comments on areas of concern included:

- Elimination of mental health services for adolescents occurring statewide due to budget cuts.
- Connecting behavioral health to adolescents outside of the normal system.
- Smoking and drug and alcohol treatment and prevention strategies.
- Prevent/reduce/end domestic violence which is part of preventing child abuse and neglect.
- Intergenerational health over the whole lifespan.Many of our seniors are tasked with raising their grandchildren.
- Teen pregnancy/child crib death/children born premature.
- Reducing obesity in young children before they become adolescents.

A report of the online survey results as of 7/14/15 are in the Supporting Documents.
Following submission of the Title V application to the federal MCH Bureau in July 2015, FHSD will post the final Title V application on the DOH website with a survey link for public input. FHSD will also post to the DOH facebook page information about the Title V application and survey link.

Public input comments are being used to refine the Title V application and plans.

II.F.7. Technical Assistance

As noted in Subsection II.F.2. MCH Workforce Development, Title V will submit a technical assistance (TA) request to support piloting a Leadership Training Institute for program staff. An additional TA request is included in this report as a suggestion for Hawaii's August 28, 2015 grant review meeting.

Hawaii has been requesting a Title V overview presentation by the federal MCH Bureau to open the grant review process for a number of years. Last year, Hawaii was pleased that the video by MCH Bureau Director, Dr. Michael Liu was offered, but would also appreciate an in-person presentation.

The Title V grant review provides a great opportunity to strengthen partnerships and collaboration both within the Hawaii Title V agency and with our external partners. Hawaii's reviews are somewhat unique. Because the Title V annual report is developed with contributions from numerous staff and agency partners, normally 40 to 60 participants are invited to attend the federal grant review including neighbor island staff who fly into Honolulu to attend in person. Many of our external partners attend the Review or send a staff representative. FHSD routinely receives input on the valuable information presented regarding the scope of FHSD's work.

An overview would provide essential background/orientation information to help staff and partners understand MCH as a field in public health, introduce the MCH Bureau, and the important purpose of the Title V grant to improving MCH health. A review of the key components of the new grant guidance will also help program and administrative staff appreciate the utility of the information they are reporting. A presentation similar to the one offered at the AMCHP conference this year would be appreciated.

It may also be helpful for Reviewers/the MCH Bureau to provide a short introduction to each of the report sections of grant to be reviewed so participants have a clear understanding of the purpose for the section and to help FHSD improve reporting next year.

III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 2,270,185	$ 1,724,420	$ 2,229,698	$ 1,729,375
Unobligated Balance	$ 475,518	$ 673,794	$ 93,332	$ 435,963
State Funds	$ 23,985,044	$ 23,324,254	$ 23,785,948	$ 23,369,691
Local Funds	$ 0	$ 0	$ 0	$ 0
Other Funds	$ 75,000	$ 66,515	$ 75,000	$ 69,555
Program Funds	$ 10,750,224	$ 9,922,185	$ 11,043,354	$ 9,579,148
SubTotal	$ 37,555,971	$ 35,711,168	$ 37,227,332	$ 35,183,732
Other Federal Funds	$ 48,814,287	$ 45,650,130	$ 45,736,612	$ 45,650,832
Total	$ 86,370,258	$ 81,361,298	$ 82,963,944	$ 80,834,564

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 2,024,653	$ 1,486,740	$ 2,144,047	$
Unobligated Balance	$ 0	$ 332,197	$ 228,563	$
State Funds	$ 25,296,742	$ 23,049,391	$ 25,217,539	$
Local Funds	$ 0	$ 0	$ 0	$
Other Funds	$ 75,000	$ 13,760	$ 75,000	$
Program Funds	$ 19,135,183	$ 9,924,594	$ 19,172,085	$
SubTotal	$ 46,531,578	$ 34,806,682	$ 46,837,234	$
Other Federal Funds	$ 47,260,340		$ 45,034,232	$
Total	$ 93,791,918	$ 34,806,682	$ 91,871,466	$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
Federal Allocation	$ 2,156,997	$
Unobligated Balance	$ 422,453	$
State Funds	$ 28,911,631	$
Local Funds	$ 0	$
Other Funds	$ 75,000	$
Program Funds	$ 16,520,311	$
SubTotal	$ 48,086,392	$
Other Federal Funds	$ 54,186,151	$
Total	$ 102,272,543	$

III.A. Expenditures

EXPENDITURES

Significant Budget Variations – Form 2 (Fiscal Year 2014)

Item 1. Federal Allocation. The estimated award for the fiscal year 2014 Title V Block Grant application was $2,024,653; however, the actual amount awarded to the State in fiscal year 2014 was $2,000,261.

Item 1A. Earmark for Preventive and Primary Care for Children. The amount budgeted in this category for fiscal year 2014 was $807,272; however, the amount actually expended was $666,782, a difference of $140,490. This variance is primarily due to salary and fringe benefit savings due to vacancies. The Family Health Services Division ("FHSD") did not fill vacant Title V funded positions to ensure that there were sufficient funds to meet salary, fringe benefit, and operating costs in federal fiscal year 2014.

Item 1B. Earmark for Children with Special Health Care Needs. Of the $683,731 budgeted in fiscal year 2014 for this category, a sum of $504,397 was actually expended. As mentioned above, the FHSD did not fill vacant Title V funded positions to ensure that there were sufficient grant funds to meet salary, fringe benefit, and operating costs.

Item 1C. Title V Administrative Cost. The budgeted amount for this category in fiscal year 2014 is $196,797, and the actual amount expended is $97,343. Currently, only the salary and fringe benefits for the Title V funded Public Health Administrative Officer position for FHSD is being considered as administrative costs related to the grant. The fiscal year 2014 Title V budget had originally designated two positions for this category.

Item 2. Unobligated Balance. The actual expenditures of $332,197 for the category "Unobligated Balance" was higher than the budgeted amount in fiscal year 2014 because we assumed that there would be no Title V unobligated balances in fiscal year 2014 due to sequestration. The State; however, provided the FHSD with an additional $168,301 for maternal and child health services due to sequestration.

Item 5. Other Funds. The budgeted amount in fiscal year 2014 for the category "Other Funds" was $75,000 in fiscal year 2014 and the actual expenditures amounted to $13,760, a decrease of $61,240. This decrease is a result of the elimination of the Child Death Review Coordinator position due to the State Department of Human Services,

Social Services Division's inability to continue providing funds for this position.

Item 6. Program Income. The amount budgeted for this category in fiscal year 2014 was $19,135,183, and the amount actually expended was $9,924,594. The primary reason for the variance is related to the community health centers special fund. Revenues from the cigarette taxes are deposited into this special fund account. In fiscal year 2014, the tax rate increased from 0.0075 to .0125 per cigarette sold. Based on the number of cigarettes sold in fiscal year 2013, it was estimated that the increase in the tax rate would generate revenues of approximately $12.5 million in fiscal year 2014. In actuality; however, the total revenues collected in fiscal year 2014 amounted to only $8.7 million, and the amount expended was $6.1 million. The FHSD utilizes the community health centers special fund to reimburse FQHCs for uninsured/underinsured primary care services, which includes medical, behavioral health care, and dental treatment services.

III.B. Budget

BUDGET

The State's maintenance of effort level from 1989 is $11,910,549 and the State's overmatch in fiscal year 2016 is $11,138,842. There are no continuation funding for special projects, or for special consolidated projects in fiscal year 2016.

Significant Budget Variations – Form 2 (Fiscal Year 2016)

Item 1. Federal Allocation. The "Federal Allocation" category for fiscal year 2016 amounts to $2,156,997. The Federal Allocation amount being used for the fiscal year 2016 Title V grant application is the same as the estimated Title V grant award for fiscal year 2015.

Item 1. A-C. Earmarks for Preventive and Primary Care for Children, Children with Special Health Needs, and Administrative Costs. Due to the new budget guidance requirements for fiscal year 2016, the amounts and percentages earmarked for preventive and primary care for children, children with special health care needs, and Title V administrative costs have been revised. For example, the new Form 3a which replaces the previous Form 4, no longer requires the budget category "Administration." Accordingly, adjustments were made to the application budget for fiscal year 2016 which resulted in variances when compared to the fiscal year 2015 earmarks. The budget; however, is in compliance with the required 30-30-10 percentage earmarks for fiscal year 2016.

Numerous inconsistencies in the new Forms 2, 3a, and 3b have been found. For example, on Form 3a, the system would not allow us to enter the Title V Unobligated Balance amounts into the "Federal MCH Block Grant Section." Rather, this information had to be entered into the "Non-Federal MCH Block Grant" category, or Form 2 would display error messages.

Further, our understanding is that the budget category "All Others" on the new Form 3a is intended to report services for adults; however, this category is not included as a subcategory under "Direct Services" in Form 3b.

Item 2. Unobligated Balance. The estimated unobligated balance from the federal fiscal year 2015 Title V grant application was $228,563 in comparison with the estimated unobligated balance of $422,453 in fiscal year 2016. The increase in the unobligated balance is due to the implementation of cost savings measures. For example, vacant Title V funded positions are being left unfilled to ensure that there are enough grant funds to meet salary, fringe benefit, and operating costs in federal fiscal year 2016.

Item 3. State MCH Funds. The category "State MCH Funds" has increased from $25,217,539 in fiscal year 2015 to

$28,911,631 in fiscal year 2016. The increase of $3,694,092 is primary due to the 2015 legislative appropriation of $3,000,000 in State funds for the Hawaii Home Visiting Network Program pursuant to Senate Bill Number 101.

Item 6. Program Income. The category "Program Income" has decreased from $19,172,085 in fiscal year 2015 to $16,520,311 in fiscal year 2016. This decrease is primarily due to the deletion of $3,000,000 in Tobacco Settlement Special Funds for the home visiting program.

Item 9. Other Federal Funds. The category "Other Federal Funds" has increased from $45,032,232 in fiscal year 2015 to $54,185,151 in fiscal year 2016, an increase of $9,152,919. This increase is primarily due to a new $8,430,783 Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting Program Expansion Grant.

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 - FHSD_Profiles_2014_c.pdf

Supporting Document #02 - FHSD programs 7-7-15.pdf

Supporting Document #03 - Public input documents and survey.pdf

Supporting Document #04 - Public input survey report.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Hawaii

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,156,997	$ 1,486,740
A. Preventive and Primary Care for Children	$ 737,477	$ 666,782
B. Children with Special Health Care Needs	$ 938,725	$ 504,397
C. Title V Administrative Costs	$ 115,511	$ 97,343
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 422,453	$ 332,197
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 28,911,631	$ 23,049,391
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	$ 0
5. OTHER FUNDS (Item 18e of SF-424)	$ 75,000	$ 13,760
6. PROGRAM INCOME (Item 18f of SF-424)	$ 16,520,311	$ 9,924,594
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 45,506,942	$ 32,987,745
A. Your State's FY 1989 Maintenance of Effort Amount	$ 11,910,549	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 48,086,392	$ 34,806,682
9. OTHER FEDERAL FUNDS		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 54,186,151	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 102,272,543	$ 34,806,682

	FY14 Annual Report Budgeted
1. FEDERAL ALLOCATION	$ 2,024,653
A. Preventive and Primary Care for Children	$ 807,272
B. Children with Special Health Care Needs	$ 683,731
C. Title V Administrative Costs	$ 196,797
2. UNOBLIGATED BALANCE	$ 0
3. STATE MCH FUNDS	$ 25,296,742
4. LOCAL MCH FUNDS	$ 0
5. OTHER FUNDS	$ 75,000
6. PROGRAM INCOME	$ 19,135,183
7. TOTAL STATE MATCH	$ 44,506,925

	FY16 Application Budgeted
9. OTHER FEDERAL FUNDS	
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Program (CBCAP);	$ 317,933
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) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program;	$ 156,881
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Basic Screening Survey (BSS);	$ 230,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS);	$ 144,078
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant;	$ 40,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and	$ 255,086

Education (RPE) Program;	
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program;	$ 9,430,783
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration;	$ 157,402
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) > State Systems Development Initiative (SSDI);	$ 95,374
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention;	$ 250,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning;	$ 2,157,300
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC);	$ 37,081,166
US Department of Education > Office of Special Education Programs > Early Identification and Intervention Infants/Toddlers;	$ 2,148,926
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Office of Rura;	$ 185,737
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Hospital Flexi;	$ 406,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospita;	$ 111,491
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care O;	$ 167,994

Form Notes For Form 2:

PLEASE Note that the "Unobligated Balance" dollars are Previous Title V funds. For the FY 2016 Application (Budgeted) The unobligated funds are actually Title V funds from the prior year's grant (FY 2015) that have not been expended. For the FY 2014 Annual Report (Expended) The unobligated funds that are being reported in the FY 2014 Annual Report are Title V funds that were expended from the prior year's grant award (FY 2013). Item 9. Other Federal Funds. The category "Other Federal Funds" has increased from $45,032,232 in fiscal year 2015 to $54,185,151 in fiscal year 2016, an increase of $9,152,919. This increase is primarily due to a new $8,430,783 Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting Program Expansion Grant.

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: The "Federal Allocation" category for fiscal year 2016 amounts to $2,156,997. The Federal Allocation amount being used for the fiscal year 2016 Title V grant application is the same as the estimated Title V grant award for fiscal year 2015.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Item 1. A-C. Earmarks for Preventive and Primary Care for Children, Children with Special Health Needs, and Administrative Costs. Due to the new budget guidance requirements for fiscal year 2016, the amounts and percentages earmarked for preventive and primary care for children, children with special health care needs, and Title V administrative costs have been revised. For example, the new Form 3a which replaces the previous Form 4, no longer requires the budget category "Administration." Accordingly, adjustments were made to the application budget for fiscal year 2016 which resulted in variances when compared to the fiscal year 2015 earmarks. The budget, however, is in compliance with the required 30-30-10 percentage earmarks for fiscal year 2016. *** comments continue in tem 1B. ***	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: *** continuation fro item 1A. field comments. *** Numerous inconsistencies in the new Forms 2, 3a, and 3b have been found. For example, on Form 3a, the system would not allow us to enter the Title V Unobligated Balance amounts into the "Federal MCH Block Grant Section." Rather, this information had to be entered into the "Non-Federal MCH Block Grant" category, or Form 2 would display error messages. Further, our understanding is that the budget category "All Others" on the new Form 3a is intended to report services for adults, however this category is not included as a subcategory under "Direct Services" in Form 3b.	

4.	**Field Name:**	**2. UNOBLIGATED BALANCE**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**

Field Note:
The estimated unobligated balance from the federal fiscal year 2015 Title V grant application was $228,563 in comparison with the estimated unobligated balance of $422,453 in fiscal year 2016. The increase in the unobligated balance is due the implementation of cost savings measures. For example, vacant Title V funded positions are being left unfilled to ensure that there are enough grant funds to meet salary, fringe benefit, and operating costs in federal fiscal year 2016.

5.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**

Field Note:
The category “State MCH Funds” has increased from $25,217,539 in fiscal year 2015 to $28,911,631 in fiscal year 2016. The increase of $3,694,092 is primary due to the 2015 legislative appropriation of $3,000,000 in State funds for the Hawaii Home Visiting Network Program pursuant to Senate Bill Number 101.

6.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**

Field Note:
The category “Program Income” has decreased from $19,172,085 in fiscal year 2015 to $16,520,311 in fiscal year 2016. This decrease is primarily due to the deletion of $3,000,000 in Tobacco Settlement Special Funds for the home visiting program.

7.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**

Field Note:
The amount budgeted in this category for fiscal year 2014 was $807,272, however the amount actually expended was $666,782, a difference of $140,490. This variance is primarily due to salary and fringe benefit savings due to vacancies. The Family Health Services Division (“FHSD”) did not fill vacant Title V funded positions to ensure that there were sufficient funds to meet salary, fringe benefit, and operating costs in federal fiscal year 2014.

8.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**

Field Note:
Of the $683,731 budgeted in fiscal year 2014 for this category, a sum of $504,397 was actually expended. As

mentioned above, the Family Health Services Division did not fill vacant Title V funded positions to ensure that there were sufficient grant funds to meet salary, fringe benefit, and operating costs.

9.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**

Field Note:
The budgeted amount for this category in fiscal year 2014 is $196,797, and the actual amount expended is $97,343. Currently, only the salary and fringe benefits for the Title V funded Public Health Administrative Officer position for FHSD is being considered as administrative costs related to the grant. The fiscal year 2014 Title V budget had originally designated two positions for this category.

10.	**Field Name:**	**2. UNOBLIGATED BALANCE**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**

Field Note:
The actual expenditures of $332,197 for the category “Unobligated Balance” was higher than the budgeted amount in fiscal year 2014 because we assumed that there would be no Title V unobligated balances in fiscal year 2014 due to sequestration. The State, however, provided the Family Health Services Division with an additional $168,301 for maternal and child health services due to sequestration.

11.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**

Field Note:
The budgeted amount in fiscal year 2014 for the category “Other Funds” was $75,000 in fiscal year 2014 and the actual expenditures amounted to $13,760, a decrease of $61,240. This decrease is a result of the elimination of the Child Death Review Coordinator position due to the State Department of Human Services, Social Services Division’s inability to continue providing funds for this position.

12.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**

Field Note:
The amount budgeted for this category in fiscal year 2014 was $19,135,183, and the amount actually expended was $9,924,594. The primary reason for the variance is related to the community health centers special fund. Revenues from the cigarette taxes are deposited into this special fund account. In fiscal year 2014, the tax rate increased from 0.0075 to .0125 per cigarette sold. Based on the number of cigarettes sold in fiscal year 2013, it was estimated that the increase in the tax rate would generate revenues of approximately $12.5 million in fiscal year 2014. In actuality, however, the total revenues collected in fiscal year 2014 amounted to only $8.7 million, and the amount expended was $6.1 million. The FHSD utilizes the community health centers special fund to reimburse FQHCs for uninsured/underinsured primary care services, which includes medical, behavioral health care, and dental treatment services.

13.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: The estimated award for the fiscal year 2014 Title V Block Grant application was $2,024,653, however the actual amount awarded to the State in fiscal year 2014 was $2,000,261.	
14.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Office of Rura**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: State Office of Rural Health	
15.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Hospital Flexi**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Rural Hospital Flexibility Program	
16.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospita**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Small Rural Hospital Improvement Grant Program	
17.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care O**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: State Primary Care Offies	

Data Alerts:

None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Hawaii

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF INDIVIDUALS SERVED		
IA. Federal MCH Block Grant		
1. Pregnant Women	$ 208,151	$ 179,034
2. Infants < 1 year	$ 35,153	$ 39,184
3. Children 1-22 years	$ 737,477	$ 666,782
4. CSHCN	$ 938,725	$ 504,397
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 1,919,506	$ 1,389,397
IB. Non Federal MCH Block Grant		
1. Pregnant Women	$ 4,736,663	$ 2,634,670
2. Infants < 1 year	$ 3,948,897	$ 2,284,494
3. Children 1-22 years	$ 9,800,773	$ 6,892,225
4. CSHCN	$ 20,304,922	$ 16,359,934
5. All Others	$ 7,138,140	$ 5,148,619
Federal Total of Individuals Served	$ 45,929,395	$ 33,319,942
Federal State MCH Block Grant Partnership Total	$ 47,848,901	$ 34,709,339

Form Notes For Form 3a:

We did not update IB. "Non-Federal MCH Block Grant" for the following reason. The change to the calculation to calculate the non-federal totals was made to exclude line 2 unobligated balance and include only lines 3 to 6. However, an offsetting adjustment to change the calculation to the federal totals were not made. For Hawaii the calculation for federal totals for Forms 3a and 3b should have included from Form 2, line 1 federal allocation and line 2 unobligated balance. For Form 3a, if we did not make the adjustment to include the unobligated balance into federal MCH block grant totals to offset the decrease in the non-federal MCH block grant totals, then the “Federal State MCH Block Grant Partnership Total” would be less than what it should be because it would be excluding the unobligated balance totals.

Field Level Notes for Form 3a:

None

Data Alerts:

None

Form 3b
Budget and Expenditure Details by Types of Services

State: Hawaii

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
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	$ 461,382	$ 277,128
3. Public Health Services and Systems	$ 1,695,615	$ 1,209,612
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 Total		$ 0
Federal Total	$ 2,156,997	$ 1,486,740

IIB. Non-Federal MCH Block Grant

1. Direct Services	$ 24,759,719	$ 18,368,316
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 6,093,737	$ 3,649,806
B. Preventive and Primary Care Services for Children	$ 8,216,761	$ 6,005,143
C. Services for CSHCN	$ 10,449,221	$ 8,713,367
2. Enabling Services	$ 11,567,687	$ 8,178,327
3. Public Health Services and Systems	$ 9,601,989	$ 6,773,299
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		$ 2,408,050
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 3,320,903
Dental Care (Does Not Include Orthodontic Services)		$ 1,226,735
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Primary and Urgent Care in Hana		$ 1,130,000
Waianae Coast Emergency Rooms Services		$ 1,468,000
Early Intervention Services (POS)		$ 8,814,628
Direct Services Total		$ 18,368,316
Non-Federal Total	$ 45,929,395	$ 33,319,942

Form Notes For Form 3b:

We did not update IIB. "Non-Federal MCH Block Grant" for the following reason. The change to the calculation to calculate the non-federal totals was made to exclude line 2 unobligated balance and include only lines 3 to 6. However, an offsetting adjustment to change the calculation to the federal totals were not made. For Hawaii the calculation for federal totals for Forms 3a and 3b should have included from Form 2, line 1 federal allocation and line 2 unobligated balance.

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 18,803

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Propionic acidemia	18,556 (98.7%)	10	0	0 (0%)
Methylmalonic acidemia (methylmalonyl-CoA mutase)	18,556 (98.7%)	10	0	0 (0%)
Methylmalonic acidemia (cobalamin disorders)	18,556 (98.7%)	10	0	0 (0%)
Isovaleric acidemia	18,556 (98.7%)	35	1	1 (100.0%)
3-Methylcrotonyl-CoA carboxylase deficiency	18,556 (98.7%)	1	0	0 (0%)
3-Hydroxy-3-methyglutaric aciduria	18,556 (98.7%)	1	0	0 (0%)
Holocarboxylase synthase deficiency	18,556 (98.7%)	0	0	0 (0%)
ß-Ketothiolase deficiency	18,556 (98.7%)	0	0	0 (0%)
Glutaric acidemia type I	18,556 (98.7%)	2	0	0 (0%)
Carnitine uptake defect/carnitine transport defect	18,556 (98.7%)	3	0	0 (0%)
Medium-chain acyl-CoA dehydrogenase deficiency	18,556 (98.7%)	4	0	0 (0%)
Very long-chain acyl-CoA dehydrogenase deficiency	18,556 (98.7%)	10	2	2 (100.0%)
Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	18,556 (98.7%)	0	0	0 (0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Trifunctional protein deficiency	18,556 (98.7%)	0	0	0 (0%)
Argininosuccinic aciduria	18,556 (98.7%)	0	0	0 (0%)
Citrullinemia, type I	18,556 (98.7%)	0	0	0 (0%)
Maple syrup urine disease	18,556 (98.7%)	26	0	0 (0%)
Homocystinuria	18,556 (98.7%)	94	0	0 (0%)
Classic phenylketonuria	18,556 (98.7%)	18	0	0 (0%)
Tyrosinemia, type I	18,556 (98.7%)	10	0	0 (0%)
Primary congenital hypothyroidism	18,556 (98.7%)	128	7	7 (100.0%)
Congenital adrenal hyperplasia	18,556 (98.7%)	10	1	1 (100.0%)
S,S disease (Sickle cell anemia)	18,556 (98.7%)	1	1	1 (100.0%)
S, βeta-thalassemia	18,556 (98.7%)	1	1	1 (100.0%)
S,C disease	18,556 (98.7%)	0	0	0 (0%)
Biotinidase deficiency	18,556 (98.7%)	0	0	0 (0%)
Cystic fibrosis	18,556 (98.7%)	17	3	3 (100.0%)
Hearing loss	18,556 (98.7%)	0	0	0 (0%)
Classic galactosemia	18,556 (98.7%)	133	0	0 (0%)

1b. Secondary RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Methylmalonic acidemia with homocystinuria	18,556 (98.7%)	0	0	0 (0%)
Malonic acidemia	18,556 (98.7%)	8	0	0 (0%)
Isobutyrylglycinuria	18,556 (98.7%)	0	0	0 (0%)
2-Methylbutyrylglycinuria	18,556 (98.7%)	0	0	0 (0%)
3-Methylglutaconic aciduria	18,556 (98.7%)	0	0	0 (0%)
2-Methyl-3-hydroxybutyric aciduria	18,556 (98.7%)	0	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	18,556 (98.7%)	0	0	0 (0%)
Medium/short-chain L-3-hydroxyacl-CoA dehydrogenase deficiency	18,556 (98.7%)	6	0	0 (0%)
Glutaric acidemia type II	18,556 (98.7%)	0	0	0 (0%)
Medium-chain ketoacyl-CoA thiolase deficiency	18,556 (98.7%)	0	0	0 (0%)
2,4 Dienoyl-CoA reductase deficiency	18,556 (98.7%)	0	0	0 (0%)
Carnitine palmitoyltransferase type I deficiency	18,556 (98.7%)	12	1	1 (100.0%)
Carnitine palmitoyltransferase type II deficiency	18,556 (98.7%)	2	0	0 (0%)
Carnitine acylcarnitine translocase deficiency	18,556 (98.7%)	0	0	0 (0%)
Argininemia	18,556 (98.7%)	15	0	0 (0%)
Citrullinemia, type II	18,556 (98.7%)	0	0	0 (0%)
Hypermethioninemia	18,556	0	0	0

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
	(98.7%)			(0%)
Benign hyperphenylalaninemia	18,556 (98.7%)	0	0	0 (0%)
Biopterin defect in cofactor biosynthesis	18,556 (98.7%)	0	0	0 (0%)
Biopterin defect in cofactor regeneration	18,556 (98.7%)	0	0	0 (0%)
Tyrosinemia, type II	18,556 (98.7%)	0	0	0 (0%)
Tyrosinemia, type III	18,556 (98.7%)	0	0	0 (0%)
Various other hemoglobinopathies	18,556 (98.7%)	432	10	10 (100.0%)
Galactoepimerase deficiency	18,556 (98.7%)	0	0	0 (0%)
Galactokinase deficiency	18,556 (98.7%)	0	0	0 (0%)

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	18,218 (96.9%)	167	43	43 (100.0%)

3. Screening Programs for Older Children & Women

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 follow-through by patients, health status of child, and any social or other issues present. This is done by the NBMS staff, CSHNB Social Workers or the state Public Health Nurses.

Form Notes For Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Propionic acidemia - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
2.	**Field Name:**	**Methylmalonic acidemia (methylmalonyl-CoA mutase) - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
3.	**Field Name:**	**Methylmalonic acidemia (cobalamin disorders) - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
4.	**Field Name:**	**Isovaleric acidemia - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Confirmed	
5.	**Field Name:**	**3-Methylcrotonyl-CoA carboxylase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
6.	**Field Name:**	**3-Hydroxy-3-methyglutaric aciduria - Referred For Treatment**
	Fiscal Year:	**2014**

	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
7.	**Field Name:**	**Holocarboxylase synthase deficiency - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Confirmed	
8.	**Field Name:**	**Holocarboxylase synthase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
9.	**Field Name:**	**ß-Ketothiolase deficiency - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Confirmed	
10.	**Field Name:**	**ß-Ketothiolase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
11.	**Field Name:**	**Glutaric acidemia type I - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
12.	**Field Name:**	**Carnitine uptake defect/carnitine transport defect - Referred For Treatment**
	Fiscal Year:	**2014**

	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
13.	**Field Name:**	**Medium-chain acyl-CoA dehydrogenase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
14.	**Field Name:**	**Very long-chain acyl-CoA dehydrogenase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Confirmed	
15.	**Field Name:**	**Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Confirmed	
16.	**Field Name:**	**Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
17.	**Field Name:**	**Trifunctional protein deficiency - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Confirmed	
18.	**Field Name:**	**Trifunctional protein deficiency - Referred For Treatment**

	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
19.	**Field Name:**	**Argininosuccinic aciduria - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Confirmed	
20.	**Field Name:**	**Argininosuccinic aciduria - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
21.	**Field Name:**	**Citrullinemia, type I - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Confirmed	
22.	**Field Name:**	**Citrullinemia, type I - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
23.	**Field Name:**	**Maple syrup urine disease - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
24.	**Field Name:**	**Homocystinuria - Referred For Treatment**
	Fiscal Year:	**2014**

	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
25.	**Field Name:**	**Classic phenylketonuria - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
26.	**Field Name:**	**Tyrosinemia, type I - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
27.	**Field Name:**	**Primary congenital hypothyroidism - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Confirmed	
28.	**Field Name:**	**Congenital adrenal hyperplasia - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Confirmed	
29.	**Field Name:**	**S,S disease (Sickle cell anemia) - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Confirmed	
30.	**Field Name:**	**S,S disease (Sickle cell anemia) - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**

	Field Note: Confirmed	
31.	**Field Name:**	**S, βeta-thalassemia - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Confirmed	
32.	**Field Name:**	**S, βeta-thalassemia - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Confirmed	
33.	**Field Name:**	**S,C disease - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Confirmed	
34.	**Field Name:**	**S,C disease - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
35.	**Field Name:**	**Biotinidase deficiency - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Confirmed	
36.	**Field Name:**	**Biotinidase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	

37.	**Field Name:**	**Cystic fibrosis - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Confirmed	
38.	**Field Name:**	**Hearing loss - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Confirmed	
39.	**Field Name:**	**Hearing loss - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
40.	**Field Name:**	**Classic galactosemia - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
41.	**Field Name:**	**Methylmalonic acidemia with homocystinuria - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
42.	**Field Name:**	**Methylmalonic acidemia with homocystinuria - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
43.	**Field Name:**	**Malonic acidemia - Referred For Treatment**

	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
44.	**Field Name:**	**Isobutyrylglycinuria - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
45.	**Field Name:**	**Isobutyrylglycinuria - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
46.	**Field Name:**	**2-Methylbutyrylglycinuria - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
47.	**Field Name:**	**2-Methylbutyrylglycinuria - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
48.	**Field Name:**	**3-Methylglutaconic aciduria - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
49.	**Field Name:**	**3-Methylglutaconic aciduria - Referred For Treatment**
	Fiscal Year:	**2014**

	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
50.	**Field Name:**	**2-Methyl-3-hydroxybutyric aciduria - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
51.	**Field Name:**	**2-Methyl-3-hydroxybutyric aciduria - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
52.	**Field Name:**	**Short-chain acyl-CoA dehydrogenase deficiency - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
53.	**Field Name:**	**Short-chain acyl-CoA dehydrogenase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
54.	**Field Name:**	**Medium/short-chain L-3-hydroxyacl-CoA dehydrogenase deficiency - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
55.	**Field Name:**	**Medium/short-chain L-3-hydroxyacl-CoA dehydrogenase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**

	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
56.	**Field Name:**	**Glutaric acidemia type II - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
57.	**Field Name:**	**Glutaric acidemia type II - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
58.	**Field Name:**	**Medium-chain ketoacyl-CoA thiolase deficiency - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
59.	**Field Name:**	**Medium-chain ketoacyl-CoA thiolase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
60.	**Field Name:**	**2,4 Dienoyl-CoA reductase deficiency - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
61.	**Field Name:**	**2,4 Dienoyl-CoA reductase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**

	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
62.	**Field Name:**	**Carnitine palmitoyltransferase type I deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
63.	**Field Name:**	**Carnitine palmitoyltransferase type II deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
64.	**Field Name:**	**Carnitine acylcarnitine translocase deficiency - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
65.	**Field Name:**	**Carnitine acylcarnitine translocase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
66.	**Field Name:**	**Argininemia - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
67.	**Field Name:**	**Citrullinemia, type II - Confirmed Cases**
	Fiscal Year:	**2014**

	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
68.	**Field Name:**	**Citrullinemia, type II - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
69.	**Field Name:**	**Hypermethioninemia - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
70.	**Field Name:**	**Hypermethioninemia - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
71.	**Field Name:**	**Benign hyperphenylalaninemia - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
72.	**Field Name:**	**Benign hyperphenylalaninemia - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
73.	**Field Name:**	**Biopterin defect in cofactor biosynthesis - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**

	Field Note: Confirmed	
74.	**Field Name:**	**Biopterin defect in cofactor biosynthesis - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
75.	**Field Name:**	**Biopterin defect in cofactor regeneration - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
76.	**Field Name:**	**Biopterin defect in cofactor regeneration - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
77.	**Field Name:**	**Tyrosinemia, type II - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
78.	**Field Name:**	**Tyrosinemia, type II - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
79.	**Field Name:**	**Tyrosinemia, type III - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	

80.	**Field Name:**	**Tyrosinemia, type III - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
81.	**Field Name:**	**Various other hemoglobinopathies - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
82.	**Field Name:**	**Galactoepimerase deficiency - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
83.	**Field Name:**	**Galactoepimerase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	
84.	**Field Name:**	**Galactokinase deficiency - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Confirmed	
85.	**Field Name:**	**Galactokinase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Verified no confirmed cases, therefore there are no referred for treatment.	

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Hawaii

Reporting Year 2014

		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	0	0.0	0.0	0.0	0.0	100.0
2. Infants < 1 Year of Age	18,559	33.0	0.0	62.0	5.0	0.0
3. Children 1 to 22 Years of Age	3,001	0.0	0.0	0.0	41.0	59.0
4. Children with Special Health Care Needs	5,603	48.0	0.0	25.0	1.0	26.0
5. Others	12,445	0.0	0.0	0.0	100.0	0.0
Total	39,608					

Form Notes For Form 5a:

Data reported for Form 5a are from the state funded portions of the following programs: Family Planning Contracts, Primary Care Office, Children with Special Health Needs Program, Genetics Program, Newborn Metabolic Screening Program, Newborn Hearing Screening Program, and Early Intervention Section. No direct services are funded by the Title V grant. The count coming from within each program is unduplicated, but the count between programs may be duplicated since this is no system which links these program together that can identify the individuals between programs. The number of infants served is estimated since there a several population based programs serving infants including the newborn hearing/metabolic screening programs and WIC. The number is calculated based on The Total Births by Occurrence reported on Form 4 multiplied by the percent of infants receiving at least one screen on Form 4. This year the percentage is 98.7%.

Field Level Notes for Form 5a:

None

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Hawaii

Reporting Year 2014

Types Of Individuals Served	Total Served
1. Pregnant Women	18,916
2. Infants < 1 Year of Age	18,599
3. Children 1 to 22 Years of Age	394,877
4. Children with Special Health Care Needs	17,511
5. Others	156,045
Total	605,948

Form Notes For Form 5b:

Data on Form 5b include numbers reported in Form 5a (since these programs also offer enabling services) with the addition of clients served by the following programs: Abstinence Education Grant, Adolescent Health, Big Island Perinatal Health Disparities, Children and Youth with Special Health Needs Section, Community based Child Abuse and Neglect Prevention, Domestic Violence Prevention, Early Childhood Comprehensive Systems, Fetal Alcohol Spectrum Disorder, Hawaii Birth Defects, Hawaii Medicare Rural Hospital Flexibility, Home Visiting, Parenting Support, Perinatal Support Services, Personal Responsibility Education Program, Reproductive Health Services, Sexual Violence Prevention, WIC. The number of infants served is obtained by using the following calculation. The Total Births by Occurrence reported on Form 4 multiplied by the percent of infants receiving at least one screen on Form 4. This year the percentage is 98.7%.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2014**
	Field Note: Estimate based on birth numbers	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2014**
	Field Note: Data pulled from initial Form 5a.	
3.	**Field Name:**	**Children 1 to 22 Year of Age**
	Fiscal Year:	**2014**
	Field Note: Census estimate	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2014**
	Field Note: Percentage of CSHN served.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2014**
	Field Note: Census estimate based on households with children	
6.	**Field Name:**	**Total Served**
	Fiscal Year:	**2014**
	Field Note: Estimates for individuals served are based on census data and vital statistics as there was no way to calculated an unduplicated estimates based on program participation.	

Form 6

Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Hawaii

Reporting Year 2014

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	18,567	4,451	602	242	6,297	6,550	0	425
Title V Served	18,325	4,393	594	239	6,215	6,465	0	419
Eligible for Title XIX	9,532	2,178	66	19	2,723	2,650	0	1,896
2. Total Infants in State	13,767	824	622	17	5,601	6,071	0	632
Title V Served	13,588	813	614	17	5,528	5,992	0	624
Eligible for Title XIX	9,460	1,775	15	3	2,030	1,076	0	4,561

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	15,757	2,762	48	18,567
Title V Served	15,552	2,726	47	18,325
Eligible for Title XIX	7,670	344	1,518	9,532
2. Total Infants in State	7,676	6,091	0	13,767
Title V Served	7,576	6,012	0	13,588
Eligible for Title XIX	4,919	87	4,454	9,460

Form Notes For Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: 2013 is the most recent data available from DHS.	
2.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: 2011 is the most recent data available from the Hawaii Health Survey.	
3.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: 2013 is the most recent data available from DHS.	

Form 7

State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Hawaii

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
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"	Tammie Smith Visperas	Tammie Smith Visperas
4. Contact Person's Telephone Number	(808) 681-1541	(808) 681-1541
5. Number of Calls Received on the State MCH "Hotline"		2,225
B. Other Appropriate Methods		
1. Other Toll-Free "Hotline" Names	The Early Intervention Referral Line	HIKISS
2. Number of Calls on Other Toll-Free "Hotlines"		2,874
3. State Title V Program Website Address	http://health.hawaii.gov/fhsd/	http://health.hawaii.gov/fhsd/
4. Number of Hits to the State Title V Program Website		1,773
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

Application Year 2016

1. Title V Maternal and Child Health (MCH) Director

Name	TBD
Title	Chief, Family Health Services Division (FHSD)
Address 1	P.O. Box 3378
Address 2	
City / State / Zip Code	Honolulu / HI / 96801
Telephone	(808) 586-4122
Email	FHSD.Chief@doh.hawaii.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Patricia Heu, M.D.
Title	Chief, Children with Special Health Needs Branch
Address 1	741 Sunset Avenue
Address 2	
City / State / Zip Code	Honolulu / HI / 96816
Telephone	(808) 733-9070
Email	patricia.heu@doh.hawaii.gov

3. State Family or Youth Leader (Optional)

Name	Leolinda Parlin
Title	Director, Hilopaa Family to Family Health Informat
Address 1	1319 Punahou Street, 7th Floor
Address 2	
City / State / Zip Code	Honolulu / HI / 96826
Telephone	(808) 791-3467
Email	leo@hilopaa.org

Form Notes For Form 8:

Actual Title for item 3 "State Family or Youth Leader Contact person" is ""Director, Hilopa'a Family to Family Health Information Center"".

Form 9
List of MCH Priority Needs

State: Hawaii

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 and NOMs:

None

NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester

FAD Not Available for this measure.

NOM-1 Notes:

Hawaii converted to the 2003 revision of the birth certificate with 2014 births. This NOM should be available in the Federally Available Data in the 2016 Title V Application year.

Data Alerts:

None

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	131.2	9.2 %	205	15,625
2011	104.2	8.2 %	162	15,550
2010	63.0	6.4 %	98	15,556
2009	71.5	6.7 %	113	15,797
2008	73.5	6.7 %	119	16,199

Legends:
Indicator has a numerator ≤10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-2 Notes:

None

Data Alerts:

None

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

FAD Not Available for this measure.

NOM-3 Notes:

Hawaii converted to the 2003 revision of the birth certificate with 2014 births. This NOM should be available in the Federally Available Data in the 2016 Title V Application year.

Data Alerts:

1.	Data has not been entered for NOM #3. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	8.2 %	0.2 %	1,562	18,970
2012	8.1 %	0.2 %	1,542	18,975
2011	8.2 %	0.2 %	1,557	18,947
2010	8.4 %	0.2 %	1,584	18,972
2009	8.4 %	0.2 %	1,592	18,872

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.1 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.4 %	0.1 %	263	18,970
2012	1.2 %	0.1 %	231	18,975
2011	1.2 %	0.1 %	232	18,947
2010	1.2 %	0.1 %	222	18,972
2009	1.4 %	0.1 %	264	18,872

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.2 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.9 %	0.2 %	1,299	18,970
2012	6.9 %	0.2 %	1,311	18,975
2011	7.0 %	0.2 %	1,325	18,947
2010	7.2 %	0.2 %	1,362	18,972
2009	7.0 %	0.2 %	1,328	18,872

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.3 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	10.2 %	0.2 %	1,928	18,959
2012	9.9 %	0.2 %	1,885	18,964
2011	9.9 %	0.2 %	1,880	18,938
2010	10.5 %	0.2 %	1,985	18,953
2009	11.2 %	0.2 %	2,094	18,785

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.1 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.6 %	0.1 %	498	18,959
2012	2.5 %	0.1 %	472	18,964
2011	2.6 %	0.1 %	497	18,938
2010	2.8 %	0.1 %	521	18,953
2009	2.8 %	0.1 %	529	18,785

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.2 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	7.5 %	0.2 %	1,430	18,959
2012	7.5 %	0.2 %	1,413	18,964
2011	7.3 %	0.2 %	1,383	18,938
2010	7.7 %	0.2 %	1,464	18,953
2009	8.3 %	0.2 %	1,565	18,785

Legends:

Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.3 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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
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
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
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
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
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
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
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 a confidence interval width >20% and should be interpreted with caution

NOM-10 Notes:

None

Data Alerts:

None

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

2012	2.5	0.4 %	39	15,625
2011	2.3	0.4 %	36	15,550
2010	1.7	0.3 %	27	15,556
2009	1.8	0.3 %	28	15,797
2008	1.8	0.3 %	29	16,199

Legends:
Indicator has a numerator ≤10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-11 Notes:

None

Data Alerts:

None

NOM-12 Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-12 Notes:

None

Data Alerts:

None

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

FAD Not Available for this measure.

NOM-13 Notes:

None

Data Alerts:

None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.6 %	1.3 %	55,914	285,473

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-14 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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
2011_2013	11.4	2.2 %	28	245,750
2010_2012	11.1	7.4 %	28	251,412
2009_2011	12.5	8.5 %	32	256,302
2008_2010	11.6	7.8 %	30	259,537

Year	Annual Indicator	Standard Error	Numerator	Denominator
2007_2009	10.8	7.2 %	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
2011_2013	9.0	5.6 %	22	245,750
2010_2012	9.6	6.1 %	24	251,412
2009_2011	11.3	7.6 %	29	256,302
2008_2010	11.9	8.1 %	31	259,537
2007_2009	10.8	7.2 %	28	260,274

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.3 Notes:

None

Data Alerts:

None

NOM-17.1 Percent of children with special health care needs

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	17.1 %	1.2 %	51,895	304,085
2007	17.9 %	1.2 %	50,137	279,867
2003	15.0 %	1.0 %	44,310	296,099

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.1 Notes:

None

Data Alerts:

None

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

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	22.7 %	2.1 %	7,254	31,949

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.2 Notes:

None

Data Alerts:

None

NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	1.3 %	0.4 %	3,373	252,498
2007	0.6 %	0.2 %	1,416	229,332

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.3 Notes:

None

Data Alerts:

None

NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	5.7 %	0.8 %	14,236	251,557
2007	4.2 %	0.7 %	9,502	228,582

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.4 Notes:

None

Data Alerts:

None

NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	58.7 %	6.2 %	11,474	19,553
2007	63.0 %	6.6 %	8,602	13,660
2003	67.8 %	5.9 %	10,641	15,687

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-18 Notes:

None

Data Alerts:

None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	86.0 %	1.1 %	261,333	303,854
2007	86.7 %	1.1 %	241,938	279,051
2003	86.7 %	1.0 %	256,361	295,749

Legends:

Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-19 Notes:

None

Data Alerts:

None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	27.4 %	2.0 %	36,008	131,228
2007	28.5 %	2.1 %	34,313	120,448
2003	26.9 %	1.8 %	34,448	128,172

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	23.0 %	0.4 %	3,360	14,581

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
2013	28.3 %	1.4 %	11,359	40,213
2011	26.6 %	1.7 %	11,206	42,116
2009	27.9 %	2.5 %	13,197	47,369
2007	29.2 %	1.7 %	15,200	52,142
2005	26.8 %	1.1 %	14,021	52,303

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-20 Notes:

None

Data Alerts:

None

NOM-21 Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	66.5 %	4.2 %	17,471	26,291
2012	80.2 %	2.8 %	21,101	26,326
2011	74.8 %	3.7 %	20,233	27,044
2010	63.7 %	3.3 %	17,732	27,823
2009	46.7 %	3.9 %	12,642	27,068

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.1 Notes:

None

Data Alerts:

None

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	75.0 %	3.1 %	60,003	80,038
2012	70.4 %	3.2 %	58,019	82,379
2011	70.2 %	3.0 %	58,282	83,036
2010	64.5 %	3.0 %	52,417	81,309
2009	51.0 %	3.5 %	40,094	78,650

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.5 Notes:

None

Data Alerts:

None

Form 10a
National Performance Measures (NPMs)

State: Hawaii

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	65.0	65.0	65.0	65.0	65.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	94.0	94.0	94.0	94.0	94.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	28.0	28.0	28.0	28.0	28.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	82.0	82.0	82.0	82.0	82.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	41.0	41.0	41.0	41.0	41.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	142.0	142.0	142.0	142.0	142.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	86.0	86.0	86.0	86.0	86.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	39.0	39.0	39.0	39.0	39.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.0	45.0	45.0	45.0	45.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	87.0	87.0	87.0	87.0	87.0

Form 10b

State Performance/Outcome Measure Detail Sheet

State: Hawaii

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c

Evidence-Based or Informed Strategy Measure Detail Sheet

State: Hawaii

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Hawaii

Form Notes for Form 10d NPMs and SPMs

None

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	15	22	13	27	
Denominator	15	22	13	27	
Data Source	Hawaii NMSP	Hawaii NMSP	Hawaii NMSP	Hawaii NMSP	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Numerator and denominator data are from the State Newborn Metabolic Screening Program. The State of Hawaii test for 32 disorders. The annual performance objective for the year 2015 was unchanged.	
2.	**Field Name:**	**2013**
	Field Note: Numerator and denominator data are from the State Newborn Metabolic Screening Program. The State of Hawaii tests for 32 disorders.	
3.	**Field Name:**	**2012**
	Field Note: Data are from the State Newborn Metabolic Screening Program, Department of Health. The State of Hawaii tests for 32 disorders.	
4.	**Field Name:**	**2011**
	Field Note: Data are from the State Newborn Metabolic Screening Program, Department of Health. The State of Hawaii tests for 32 disorders.	

Data Alerts:

None

NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

	2011	2012	2013	2014	2015
Annual Objective	62.5	82.0	82.0	82.0	82.0
Annual Indicator	77.6	77.6	77.6	77.6	
Numerator	26,502	26,502	26,502	26,502	
Denominator	34,131	34,131	34,131	34,131	
Data Source	National CSHCN survey	National CSHCN survey	National CSHCN survey	National CSHCN survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
2.	**Field Name:**	**2013**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

The annual performance objective for the years 2013 to 2017 was carried forward from 2012 since no new data was available. The annual performance objective will be reassessed when new data becomes available.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. Due to wording changes and additional questions, the 2005-2006 CSHCN survey are NOT comparable with the 2009-2010 CSHCN survey. Therefore the indicator generated for this measure for 2011-2014 are NOT comparable to that used for the measure from 2007-2010.

The annual performance objective for the year 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011 annual indicator.

Data Alerts:

None

NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	47.5	48.0	48.0	48.0	48.0
Annual Indicator	45.4	45.4	45.4	45.4	
Numerator	15,157	15,157	15,157	15,157	
Denominator	33,383	33,383	33,383	33,383	
Data Source	National CSHCN survey	National CSHCN survey	National CSHCN survey	National CSHCN survey	
Provisional Or Final ?				Final	

	2011	2012	2013	2014	2015

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

The annual performance objective for the years 2013 to 2017 was carried forward from 2012 since no new data was available. The annual performance objective will be reassessed when new data becomes available.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. All estimates from the National Survey of CSHCN are subject to sampling

variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The same questions were used to generate this indicator for both the 2005-2006 and 2009-2010 CSHCN surveys, therefore the indicator data from 2011-2014 are comparable to that used for the measure from 2007-2010.

The annual performance objective for the year 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011 annual indicator.

Data Alerts:

None

NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	77.5	76.0	76.0	76.0	76.0
Annual Indicator	72.6	72.6	72.6	72.6	
Numerator	24,800	24,800	24,800	24,800	
Denominator	34,158	34,158	34,158	34,158	
Data Source	National CSHCN survey	National CSHCN survey	National CSHCN survey	National CSHCN survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
2.	**Field Name:**	**2013**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to	

generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

The annual performance objective for the years 2013 to 2017 was carried forward from 2012 since no new data was available. The annual performance objective will be reassessed when new data becomes available.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The same questions were used to generate this indicator for both the 2005-2006 and 2009-2010 CSHCN surveys, therefore the indicator data from 2011-2014 are comparable to that used for the measure from 2007-2010.

The annual performance objective for the year 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011 annual indicator.

Data Alerts:

None

NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	93.0	75.0	75.0	75.0	75.0
Annual Indicator	71.5	71.5	71.5	71.5	
Numerator	24,616	24,616	24,616	24,616	
Denominator	34,430	34,430	34,430	34,430	
Data Source	National CSHCN	National CSHCN	National CSHCN	National CSHCN	

	2011	2012	2013	2014	2015
	survey	survey	survey	survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

The annual performance objective for the years 2013 to 2017 was carried forward from 2012 since no new data was available. The annual performance objective will be reassessed when new data becomes available.

4.	**Field Name:**	**2011**

Field Note:

For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. Due to extensive revisions to the questions, the 2005-2006 CSHCN survey are NOT comparable with the 2009-2010 CSHCN survey. Therefore the indicator generated for this measure for 2011-2014 are NOT comparable to that used for the measure from 2007-2010..

The annual performance objective for the year 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011 annual indicator.

Data Alerts:

None

NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

	2011	2012	2013	2014	2015
Annual Objective	42.0	40.0	40.0	40.0	40.0
Annual Indicator	37.3	37.3	37.3	37.3	
Numerator	4,714	4,714	4,714	4,714	
Denominator	12,643	12,643	12,643	12,643	
Data Source	National CSHCN survey	National CSHCN survey	National CSHCN survey	National CSHCN survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

The annual performance objective for the years 2013 to 2017 was carried forward from 2012 since no new data was available. The annual performance objective will be reassessed when new data becomes available.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The same questions were used to generate this indicator for both the 2005-2006 and 2009-2010 CSHCN surveys, therefore the indicator data from 2011-2014 are comparable to that used for the measure from 2007-2010.

The annual performance objective for the year 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011 annual indicator.

Data Alerts:

None

NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

	2011	2012	2013	2014	2015
Annual Objective	91.7	70.0	82.0	90.0	81.0
Annual Indicator	78.4	85.5	77.2	77.2	
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: May 2015, the estimate for 2013 was revised to reflect the data provided by the National Immunization Survey. The estimate for 2014 was not available at time of this report so the 2013 final estimate was carried forward. The annual performance objective for the year 2015 was changed to approximately reflect a 5 percent improvement from the 2014 annual indicator.	
2.	**Field Name:**	**2013**
	Field Note: The estimate for 2013 was not available at time of this report so the 2012 final estimate was carried forward. The annual performance objective for the years 2014 to 2018 was changed to approximately reflect a 5 percent improvement from the 2013 annual indicator.	
3.	**Field Name:**	**2012**
	Field Note: The estimate for 2012 was not available at time of this report so the 2011 final estimate was carried forward. The annual performance objective for 2012 could not be edited (as it had reflected an approximate 5 percent improvement from the 2010 annual indicator). The annual performance objective for the years 2013 to 2017 was changed to approximately reflect a 5 percent improvement from the 2011 annual indicator.	
4.	**Field Name:**	**2011**
	Field Note: The estimate for the 2011 is not available at time of this report so the 2010 estimate was carried forward. The annual performance objective for the years 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011 annual indicator.	

Data Alerts:

None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	13.0	11.0	11.0	10.0	10.0
Annual Indicator	12.0	11.8	10.4	9.6	
Numerator	297	283	246	228	
Denominator	24,703	23,966	23,681	23,681	
Data Source	Hawaii State Vital records	Hawaii State Vital records	Hawaii State Vital records	Hawaii State Vital records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Numerator: Data is from the Office of Health Status Monitoring and is based on resident population by calendar year. Data for the 2013 year was revised with an updated birth data file, while data for the 2014 year was based on a provisional birth data file. Denominator: Population data is from the U.S. Census Bureau, Population Estimates Program, via the American FactFinder, “Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2013”, filtered for the State of Hawaii. Estimates for the 2014 population were not available from the Census bureau at time of this report so the prior year estimate was used. The annual performance objective for the year 2015 was changed to approximately reflect a 5 percent improvement from the 2014 annual indicator.

2.	**Field Name:**	**2013**

Field Note:
Numerator: Data is from the Office of Health Status Monitoring and is based on resident population by calendar year. Data for the 2012 year was revised with an updated birth data file, while data for the 2013 year was based on a provisional birth data file.

Denominator: Population data is from the U.S. Census Bureau, Population Estimates Program, via the American FactFinder, “Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2012”, filtered for the State of Hawaii. Estimates for the 2013 population were not available from the Census bureau at time of this report so the prior year estimate was used.

The annual performance objective for the years 2014 to 2018 was changed to approximately reflect a 5 percent improvement from the 2013 annual indicator.

3.	**Field Name:**	**2012**

Field Note:
Data Source is the Hawaii Department of Health; Office of Health Status Monitoring.

Data is for resident population and is by calendar year. Data for the year 2011 was revised with an updated birth data file. Data for the year 2012 is based on a provisional birth data file.

Population based data on U.S. Census Bureau, Population Estimates Program, 'Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2011" (SC-EST2011-AGESEX_RES). Estimates for the 2012 population were not available from the Census bureau at time of this report so the prior year estimate was used in the determination of the indicator.

The annual performance objective for the years 2013 to 2017 was carried forward from the 2012 annual performance objective, after assessing the 2012 annual indicator.

4.	**Field Name:**	**2011**

Field Note:
Data is for resident population and is by calendar year. Data for the year 2010 was revised with an updated birth data file. Data for the year 2011 is based on a provisional birth data file.

Population based data on U.S. Census Bureau, Population Estimates Program, 'Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2011" (SC-EST2011-AGESEX_RES). Previous years have been revised based on revised population estimates.

The annual performance objective for the years 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011 annual indicator.

Data Alerts:

None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	28.0	12.0	13.0	12.0	12.0
Annual Indicator	11.6	10.9	11.4	11.8	
Numerator	3,461	3,507	3,718	3,846	
Denominator	29,852	32,204	32,491	32,615	
Data Source	EPSDT CMS-416	EPSDT CMS-416	EPSDT CMS-416	EPSDT CMS-416	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Numerator: Data is from row 12d of the EPSDT CMS-416 report. “Total Eligibles Receiving a sealant on a permanent tooth.” Denominator: Beginning in 2013 the data for the denominator used information from row 1b of the EPSDT CMS-416 report. 'Total individuals eligible for EPSDT for 90 continuous days.' Data in 2011 and 2012 were reported previously from row 13 of the EPSDT CMS-416 report. 'Total eligibles enrolled in managed care'. This change was based on discussions with the Medicaid program to align with what is reported and utilized by Medicaid. The annual performance objective for the year 2015 was changed to approximately reflect a 5 percent improvement from the 2014 annual indicator.

2.	**Field Name:**	**2013**

Field Note:
Numerator: Data is from row 12d of the EPSDT CMS-416 report. “Total Eligibles Receiving a sealant on a permanent tooth.”

Denominator: In 2013 the data for the denominator used information from row 1b of the EPSDT CMS-416 report. 'Total individuals eligible for EPSDT for 90 continuous days.' Data in 2011 and 2012 were reported previously from row 13 of the EPSDT CMS-416 report. 'Total eligibles enrolled in managed care'. This change was based on discussions with the Medicaid program to align with what is reported and utilized by Medicaid. The denominator for 2011, 2012 were revised and the measure recalculated.

The annual performance objective for the years 2014 to 2018 was changed to approximately reflect a 5 percent improvement from the 2013 annual indicator.

3.	**Field Name:**	**2012**

Field Note:
Data for this measure is from the Centers for Medicare and Medicaid Services (CMS) report form HCFA-416, Annual EPSDT Participation Report. The numerator taken from Row 12d: Total Eligibles Receiving a sealant on a permanent molar tooth. The denominator taken from Row 13: Total eligibles enrolled in managed care.

The annual performance objective for the years 2013 to 2017 was changed to approximately reflect a 5 percent improvement from the 2012 annual indicator.

4.	**Field Name:**	**2011**

Field Note:
Data is normally from the Department of Health Dental Health Division (DHD) which conducts the child oral health surveillance program. However, in November 2009 the DHD Dental Hygiene Brach was eliminated due to state budget cuts, thus ending school based oral health programs and child dental data collection. FY 2008 is the last complete year of data. The indicator for 2008 was used for 2009.

Data for 2010 and 2011 is not comparable to prior years as the data for 2010 and 2011 is generated from the EPSDT CMS-416 Report for the age group 6 to 9. Whereas previously the data was for the third grade children. The numerator value is from "Total eligibles receiving a sealant on a permanent molar tooth", while the denominator value is from "Total eligibles enrolled in managed care".

The annual performance objective for the years 2012 to 2016 was changed to reflect a 5 percent improvement

from the 2011 annual indicator.

Data Alerts:

None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	1.5	1.5	1.2	1.3	1.6
Annual Indicator	1.6	1.3	1.4	1.7	
Numerator	12	10	11	13	
Denominator	749,565	761,363	767,546	772,621	
Data Source	Hawaii State Vital records	Hawaii State Vital records	Hawaii State Vital records	Hawaii State Vital records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Due to the small number of deaths, a 3-year total is being used for the numerator and denominator. Caution should be exercised in the use of the reported data maybe too small to calculate reliable annual indicator measures. Numerator: Data is from the Office of Health Status Monitoring and based on resident population by calendar year. Data for 2013 was revised with an updated 2013 death data file, while data for the 2014 year was based on a provisional 2014 death data file. Denominator: Population data is based on U.S. Census Bureau, Population Estimates Program, via the American FactFinder. Population estimates for 2014 were not available from the Census bureau at the time of this report so the prior year estimate was used. The annual performance objective for the year 2015 was changed to approximately reflect a 5 percent improvement from the 2014 annual indicator.

2.	**Field Name:**	**2013**

Field Note:
Due to the small number of deaths, a three-year total is being used and reported for the numerator and denominator. Caution should be exercised in the use of the reported data as the data reported maybe too small to calculate a reliable annual indicator measure.

Numerator: Data is from the Office of Health Status Monitoring and based on resident population by calendar year. Data for the 2012 year was revised with an updated death data file, while data for the 2013 year was based on a provisional death data file.

Denominator: Population data is based on U.S. Census Bureau, Population Estimates Program, via the American FactFinder, “Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2012”, filtered for the State of Hawaii. Estimates for the 2013 population were not available from the Census bureau at time of this report so the prior year estimate was used.

The annual performance objective for the years 2014 to 2018 was changed to approximately reflect a 5 percent improvement from the 2013 annual indicator.

3.	**Field Name:**	**2012**

Field Note:
Data source for the numerator is the Hawaii Department of Health; Office of Health Status Monitoring, while the denominator is from the U.S. Department of Commerce; Bureau of Census.

Due to the small number of deaths, (a three-year total is used for the numerator and denominator to calculate) a three-year annual average that is being reported. The reported data maybe too small to calculate reliable measures. Caution should be exercised in the use of the reported data.

Data is for resident population and is by calendar year. Data for the year 2011 was revised with an updated death data file, while data for the year 2012 represents deaths from the updated 2010 and 2011 death files and the provisional 2012 death file. The population data is based on the U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2011" (SC-EST2009-AGESEX_RES). Estimates for the 2012 population were not available from the Census bureau at time of this report so the prior year estimate was used in the determination of the indicator.

The annual performance objective for the years 2013 to 2017 was changed to approximately reflect a 5 percent improvement from the 2012 annual indicator.

4.	**Field Name:**	**2011**

Field Note:
Data source for the numerator is the Hawaii Department of Health; Office of Health Status Monitoring, while the denominator is from the U.S. Department of Commerce; Bureau of Census.

Due to the small number of deaths, (a three-year total is used for the numerator and denominator to calculate) a three-year annual average that is being reported. The reported data maybe too small to calculate reliable measures. Caution should be exercised in the use of the reported data.

Data is for resident population and is by calendar year. Data for the year 2010 was revised with an updated death data file, while data for the year 2011 represents deaths from the updated 2009 and 2010 death files and the provisional 2011 death file. The population data is based on the U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2011" (SC-EST2009-AGESEX_RES).

Data Alerts:

None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	64.0	64.0	61.0	61.0	58.0
Annual Indicator	52.4	51.1	64.9	61.5	
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Data is from the Centers for Disease Control (CDC), 2014 Breastfeeding Report Card. Numerators and Denominators are not available. The annual performance objective for the year 2015 was changed to approximately reflect a 5 percent improvement from the 2014 annual indicator.	
2.	**Field Name:**	**2013**
	Field Note: Data is from the Centers for Disease Control (CDC), 2013 Breastfeeding Report Card. Numerators and Denominators are not available. The annual performance objective for the years 2014 to 2018 was changed to match the Healthy People 2020 objective.	
3.	**Field Name:**	**2012**
	Field Note: The data for FY 2012 is from the 2009 birth cohort of the National Immunization Survey (NIS), Centers for Disease Control (CDC) Department of Health and Human Services. Data for FY2011 and FY2012 are provisional. Numerators and Denominators are not available. The annual performance objective for the years 2013 to 2017 was changed to match the Healthy People 2020 objective.	
4.	**Field Name:**	**2011**
	Field Note: The data for FY 2011 is from the 2008 birth cohort of the National Immunization Survey (NIS), Centers for Disease Control (CDC) Department of Health and Human Services.	

Data Alerts:

None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	98.4	98.4	99.0	99.0	99.0
Annual Indicator	98.6	98.5	99.2	99.0	
Numerator	18,632	18,606	18,716	18,203	
Denominator	18,889	18,889	18,866	18,381	
Data Source	Hawaii NHSP	Hawaii NHSP	Hawaii NHSP	Hawaii NHSP	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Numerator: The numerator is the number of infants screened before discharge, as reported by hospitals to the state Newborn Hearing Screening Program for use in annual calendar year (CY) reports to the Centers for Disease Control and Prevention. Denominator: The denominator is from vital records of live births minus deaths before screening. Data for CY 2013 (Jan-Dec) were updated. Data for CY 2014 (Jan-Dec) are preliminary. The annual performance objective for the year 2015 was unchanged.	
2.	**Field Name:**	**2013**
	Field Note: Beginning in 2006, the denominator is from vital records of live births minus deaths before screening. The numerator is the number of infants screened before discharge, as reported by hospitals to the state Newborn Hearing Screening Program for use in annual calendar year (CY) reports to the Centers for Disease Control and Prevention. Data for CY 2012 (Jan-Dec) were updated. Data for CY 2013 (Jan-Dec) are preliminary. The annual performance objective for the years 2014 to 2018 was unchanged.	
3.	**Field Name:**	**2012**
	Field Note: Beginning in 2006, the denominator is from vital records of live births minus deaths before screening. The numerator is the number of infants screened before discharge, as reported by hospitals to the state Newborn Hearing Screening Program for use in annual calendar year (CY) reports to the Centers for Disease Control and Prevention. Data for CY 2011 (Jan-Dec) were updated. Data for CY 2012 (Jan-Dec) are preliminary.	

The annual performance objective for the years 2013 to 2017 was changed to approximately reflect a 5 percent improvement from the 2012 annual indicator.

4.	**Field Name:**	**2011**

Field Note:
Beginning in 2006, the denominator is from vital records of live births minus deaths before screening. The numerator is the number of infants screened before discharge, as reported by hospitals to the state Newborn Hearing Screening Program for use in annual calendar year (CY) reports to the Centers for Disease Control and Prevention. Data for CY 2009 (Jan-Dec) were updated. Data for CY 2010 (Jan-Dec) were updated. Data for CY 2011 (Jan-Dec) are preliminary

Data Alerts:

None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	2.0	2.0	2.0	3.3	2.9
Annual Indicator	3.6	3.5	3.0	3.0	
Numerator	10,980	10,463	9,335	9,335	
Denominator	304,077	302,565	306,848	306,848	
Data Source	Hawaii Health Survey	American Community Survey	American Community Survey	American Community Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Numerator & Denominator: Data is from the American Community Survey 1-year estimate. Data is for children less than 18 years with no health insurance. Data for 2013 was revised with the 2013 ACS 1-year estimate. Data for 2013 is the most recent data available, so the data from 2013 was carried forward to 2014. The annual performance objective for the year 2015 was changed to approximately reflect a 5 percent improvement from the 2014 annual indicator.

2.	**Field Name:**	**2013**

Field Note:
Numerator & Denominator: Data is from the American Community Survey. Data is for children less than 18 years

with no health insurance. Data for 2011, 2012 was revised to reflect data obtained from the ACS instead of the Hawaii Health Survey. Data for 2011, 2012, and 2013 is not comparable to previous years. Data for 2012 is the most recent data available, so the data from 2012 was carried forward to 2013.

The annual performance objective for the years 2014 to 2018 was changed to approximately reflect a 5 percent improvement from the 2013 annual indicator.

3.	**Field Name:**	**2012**

Field Note:
The data from the Hawaii Health Survey administered by the Department of Health, Office of Health Status Monitoring was available for 2011, but was not available for 2012, so data from 2011 was carried forward to 2012. It is a continuous statewide household survey of health and socio-demographic conditions.
The annual performance objective for the years 2013 to 2017 was carried forward from the 2012 annual performance objective, after assessing the 2012 annual indicator.

4.	**Field Name:**	**2011**

Field Note:
The data from the Hawaii Health Survey administered by the Department of Health, Office of Health Status Monitoring was not available for 2010, so data from 2009 was carried forward to 2010 and 2011. It is a continuous statewide household survey of health and socio-demographic conditions.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	18.0	19.0	19.0	17.0	17.0
Annual Indicator	21.5	19.5	18.1	18.4	
Numerator	3,844	3,037	3,653	3,480	
Denominator	17,879	15,590	20,210	18,943	
Data Source	PedNSS	WIC	WIC	WIC	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:

Numerator & Denominator: Data is from the Hawaii Department of Health; Family Health Services Division; Women, Infants and Children Services Branch. Data for 2006 - 2011 (final) reflects Center for Disease Control and Prevention (CDC), Pediatric Nutrition Surveillance System (PedNSS) data. Data for 2012 reflects WIC children in April 2012, since PedNSS is no longer available. Data for 2012 is not comparable to previous years. Data for 2013 represents children 2 to 5 years old in WIC enrolled from 02/01/2013-07/31/2013. The methodology for 2012 data is similar but excluded terminated certifications and therefore slightly different from 2013 which does not exclude terminated certifications. However, indicators are generally comparable. The annual performance objective for the year 2015 was unchanged.

2.	**Field Name:**	**2013**

Field Note:
Numerator & Denominator: Data is from the Hawaii Department of Health; Family Health Services Division; Women, Infants and Children Services Branch. Data for 2006 - 2011 (final) reflects Center for Disease Control and Prevention (CDC), Pediatric Nutrition Surveillance System (PedNSS) data. Data for 2012 reflects WIC children in April 2012, since PedNSS is no longer available. Data for 2012 is not comparable to previous years. Data for 2013 represents children 2 to 5 years old in WIC enrolled from 02/01/2013-07/31/2013. The methodology for 2012 data is similar but excluded terminated certifications and therefore slightly different from 2013 which does not exclude terminated certifications. However, indicators are generally comparable.

The annual performance objective for the years 2014 to 2018 was changed to approximately reflect a 5 percent improvement from the 2013 annual indicator.

3.	**Field Name:**	**2012**

Field Note:
Data from the Hawaii Department of Health; Family Health Services Division; Women, Infants and Children Services Branch.

Data for 2006 - 2011 (final) reflects Center for Disease Control and Prevention (CDC), Pediatric Nutrition Surveillance System (PedNSS) data. Data for 2012 reflects WIC children in April 2012, since PedNSS is no longer available. Data for 2012 is not comparable to previous years.

The annual performance objective for the years 2013 to 2017 was carried forward from the 2012 annual performance objective, after assessing the 2012 annual indicator.

4.	**Field Name:**	**2011**

Field Note:
Data from the Hawaii Department of Health; Family Health Services Division; Women, Infants and Children Services Branch obtained from the U.S. Department of Health and Human Services; Center for Disease Control and Prevention from the Pediatric Nutrition Surveillance System (PedNSS).

Data is from the Centers for Disease Control (CDC) Pediatric Nutrition Surveillance System (PedNSS); 2006 data is unavailable due to quality issues and 2005 data was substituted. PedNSS is scheduled to end after 2011 analysis. WIC is exploring alternative methods to obtain the data. The annual performance objective for the years 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011 annual indicator.

Data Alerts:

None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	6.2	7.0	4.5	4.5	4.5
Annual Indicator	5.0	5.0	5.0	5.0	
Numerator	926	926	926	926	
Denominator	18,410	18,410	18,410	18,410	
Data Source	Hawaii State Department of Health	Hawaii State Department of Health	Hawaii State Department of Health	Hawaii State Department of Health	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Data for this measure comes from the Pregnancy Risk Assessment Monitoring System (PRAMS) and reflects data from births that occurred in the specified year. Data for the year 2011 is the latest available from PRAMS Hawaii for women who smoke in the last 3 months of pregnancy and was carried forward to 2012, 2013 and 2014. The annual performance objective for the year 2015 was carried forward from the 2013 annual indicator which reflected an approximately 5 percent improvement from 2011.

2.	**Field Name:**	**2013**

Field Note:
Data for this measure comes from the Pregnancy Risk Assessment Monitoring System (PRAMS) and reflects data from births that occurred in the specified year.
Data for the year 2011 is the latest available from PRAMS Hawaii for women who smoke in the last 3 months of pregnancy and was carried forward to 2012 and 2013. Caution should be used when comparing data from 2009 to earlier years, as the question used in the 2009 PRAMS survey was changed from the previous PRAMS survey.

The annual performance objective for the years 2014 to 2018 was carried forward from the 2012 annual indicator which reflected an approximately 5 percent improvement from 2011.

3.	**Field Name:**	**2012**

Field Note:
Data for this measure comes from the Pregnancy Risk Assessment Monitoring System (PRAMS) and reflects data from births that occurred in the specified year. Data for the year 2011 is the latest available data for women who smoke in the last 3 months of pregnancy and was carried forward to 2012. Caution should be used when comparing data from 2009 to earlier years, as the question used in the 2009 PRAMS survey was changed from the previous PRAMS survey.

The annual performance objective for the years 2013 to 2017 was changed to approximately reflect a 5 percent

improvement from the 2011 annual indicator.

4.	**Field Name:**	**2011**

Field Note:
Data for this measure comes from the Pregnancy Risk Assessment Monitoring System (PRAMS) and reflects data from births that occurred in the specified year. Data for the year 2010 is the latest available data for women who smoke in the last 3 months of pregnancy and was carried forward to 2011. Caution should be used when comparing data from 2009 to earlier years, as the question used in the 2009 PRAMS survey was changed from the previous PRAMS survey. The annual performance objective for the years 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011 annual indicator.

Data Alerts:

None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	7.0	11.0	9.0	8.0	8.0
Annual Indicator	12.0	10.0	9.0	8.2	
Numerator	30	25	22	20	
Denominator	249,437	251,051	245,750	242,514	
Data Source	Hawaii State Vital records	Hawaii State Vital records	Hawaii State Vital records	Hawaii State Vital records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Due to the small number of suicide deaths, a 3-year total is being used for the numerator and denominator. Caution should be exercised in the use of the reported data maybe too small to calculate reliable annual indicator measures. Numerator: Data is from the Office of Health Status Monitoring and based on resident population by calendar year. Data for 2013 was revised with an updated 2013 death data file, while data for the 2014 year was based on a provisional 2014 death data file. Denominator: Population data is based on U.S. Census Bureau, Population Estimates Program, via the American FactFinder. Population estimates for 2014 were not available from the Census bureau at the time of this report so the prior year estimate was used. The annual performance objective for the year 2015 was unchanged.

2.	**Field Name:**	**2013**

Field Note:
Due to the small number of suicide deaths, a three-year total is being used and reported for the numerator and denominator. Caution should be exercised in the use of the reported data as the data reported maybe too small to calculate reliable annual indicator measure.

Numerator: Data is from the Office of Health Status Monitoring and based on resident population by calendar year. Data for the 2012 year was revised with an updated 2010, 2011, and 2012 death data file, while data for the 2013 year was based on an updated 2011 and 2012 death data file and a provisional 2013 death data file.

Denominator: Population data is based on U.S. Census Bureau, Population Estimates Program, via the American FactFinder, “Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2012”, filtered for the State of Hawaii. Estimates for the 2013 population were not available from the Census bureau at time of this report so the prior year estimate was used.

The annual performance objective for the years 2014 to 2018 was changed to approximately reflect a 5 percent improvement from the 2013 annual indicator.

3.	**Field Name:**	**2012**

Field Note:
Data source for the numerator is the Hawaii Department of Health; Office of Health Status Monitoring, while the denominator is from the U.S. Department of Commerce; Bureau of Census.

Due to the small number of suicide deaths, a three-year annual average is being reported. The reported data maybe too small to calculate reliable measures. Caution should be exercised in the use of the reported data.

Data is for resident population and is by calendar year. Data for the year 2011 was revised with an updated 2011 death data file. Data for the year 2012 represents deaths from the updated 2010 and 2011 death files and the provisional 2012 death file.

Population based data on U.S. Census Bureau, Population Estimates Program, ‘Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2011” (SC-EST2011-AGESEX_RES). Previous years have been revised based on revised population estimates. Estimates for the 2012 population were not available from the Census bureau at time of this report so the prior year estimate was used in the determination of the indicator.

The annual performance objective for the years 2013 to 2017 was changed to approximately reflect a 5 percent improvement from the 2012 annual indicator.

4.	**Field Name:**	**2011**

Field Note:
Due to the small number of suicide deaths, a three-year annual average is being reported. The reported data maybe too small to calculate reliable measures. Caution should be exercised in the use of the reported data.

Data is for resident population and is by calendar year. Data for the year 2010 was revised with an updated death data file. Data for the year 2011 is provisional.

Population based data on U.S. Census Bureau, Population Estimates Program, ‘Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2011” (SC-EST2011-AGESEX_RES). Previous years have been revised based on revised population estimates. The annual performance objective for the years 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011

annual indicator.

Data Alerts:

None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	90.0	95.0	98.0	94.0	91.0
Annual Indicator	88.3	93.8	89.7	90.5	
Numerator	203	213	235	218	
Denominator	230	227	262	241	
Data Source	Hawai'i State Vital records	Hawai'i State Vital records	Hawai'i State Vital records	Hawai'i State Vital records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Data source is the Hawaii Department of Health; Office of Health Status Monitoring. Numerator & Denominator: Data is for resident population and is by calendar year. Data for the year 2011 and 2012 was revised with an updated birth data file. Data for the year 2013 is based on a provisional birth data file. There are three medical facilities considered to be tertiary care centers in Hawai'i: 1) Kapi'olani Medical Center for Women and Children, 2) Tripler Army Medical Center and 3) Kaiser Permanente Moanalua Medical Center. The annual performance objective for the year 2015 was changed to approximately reflect a 5 percent improvement from the 2014 annual indicator.

2.	**Field Name:**	**2013**

Field Note:
Data source is the Hawaii Department of Health; Office of Health Status Monitoring.

Numerator & Denominator: Data is for resident population and is by calendar year. Data for the year 2011 and 2012 was revised with an updated birth data file. Data for the year 2013 is based on a provisional birth data file.

There are three medical facilities considered to be tertiary care centers in Hawai'i: 1) Kapi'olani Medical Center for Women and Children, 2) Tripler Army Medical Center and 3) Kaiser Permanente Moanalua Medical Center.

The annual performance objective for the years 2014 to 2018 was changed to approximately reflect a 5 percent improvement from the 2013 annual indicator.

3.	**Field Name:**	**2012**

Field Note:
Data source is the Hawaii Department of Health; Office of Health Status Monitoring.

Data is for resident population and is by calendar year. Data for the year 2011 was revised with an updated birth data file. Data for the year 2012 is based on a provisional birth data file.

There are three medical facilities considered to be tertiary care centers in Hawai‘i: 1) Kapi‘olani Medical Center for Women and Children, 2) Tripler Army Medical Center and 3) Kaiser Permanente Moanalua Medical Center.

The annual performance objective for the years 2013 to 2017 was changed to approximately reflect a 5 percent improvement from the 2012 annual indicator.

4.	**Field Name:**	**2011**

Field Note:
Data is for resident population and is by calendar year. Data for the year 2010 was revised with an updated birth data file. Data for the year 2011 is based on a provisional birth data file. There are three medical facilities considered to be tertiary care centers in Hawai‘i: 1) Kapi‘olani Medical Center for Women and Children, 2) Tripler Army Medical Center and 3) Kaiser Permanente Moanalua Medical Center. The annual performance objective for the years 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011 annual indicator.

Data Alerts:

None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	86.0	86.0	88.0	88.0	86.0
Annual Indicator	81.2	84.2	83.7	81.7	
Numerator	15,361	15,922	15,824	13,094	
Denominator	18,911	18,920	18,916	16,031	
Data Source	Hawai‘i State Vital records	Hawai‘i State Vital records	Hawai‘i State Vital records	Hawai‘i State Vital records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Numerator & Denominator: Data is from the Office of Health Status Monitoring and is based on resident population by calendar year. Data for 2013 is not comparable to prior years based on the change in 2014 to the revised birth certificate. Also, 14% of the births had missing or implausible information on PNC entry. The annual performance objective for the year 2015 was unchanged to approximately reflect a 5 percent improvement from both the 20104 annual indicator.

2.	**Field Name:**	**2013**

Field Note:
Numerator & Denominator: Data is from the Office of Health Status Monitoring and is based on resident population by calendar year. Data for the 2012 year was revised with an updated birth data file, while data for the 2013 year was based on a provisional birth data file.

The annual performance objective for the years 2014 to 2018 was unchanged, as the objective reflected an approximate 5 percent improvement from both the 2012 and 2013 annual indicator.

3.	**Field Name:**	**2012**

Field Note:
Data source is the Hawaii Department of Health; Office of Health Status Monitoring.

Data is for resident population and is by calendar year. Data for the year 2011 was revised with an updated birth data file. Data for the year 2012 is based on a provisional birth data file.

The annual performance objective for the years 2013 to 2017 was changed to approximately reflect a 5 percent improvement from the 2012 annual indicator.

4.	**Field Name:**	**2011**

Field Note:
Data is for resident population and is by calendar year. Data for the year 2010 was revised with an updated birth data file. Data for the year 2011 is based on a provisional birth data file.

Data Alerts:

None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Hawaii

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

	2011	2012	2013	2014	2015
Annual Objective	43.0	50.0	50.0	49.0	49.0
Annual Indicator	51.6	52.0	52.0	52.0	
Numerator	11,604	11,632	11,630	11,630	
Denominator	22,480	22,350	22,346	22,346	
Data Source	Hawaii State Department of Health	Hawaii State Department of Health	Hawaii State Department of Health	Hawaii State Department of Health	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
Data for this measure comes from the Hawai'i Pregnancy Risk Assessment Monitoring System (PRAMS) and Hawai'i Vital Statistics. Data for the year 2011 is the latest available from PRAMS Hawaii and was carried forward to 2012, 2013 and. The annual performance objective for the year 2015 was carried forward from the 2013 annual indicator, which reflected an approximately 5 percent improvement from 2011.

2.	**Field Name:**	**2013**

Field Note:
Data for this measure comes from the Hawai'i Pregnancy Risk Assessment Monitoring Sysytem (PRAMS) and Hawai'i Vital Statistics. Data for the year 2011 is the latest available from PRAMS Hawaii and was carried forward to 2012 and 2013. Data from Vital Statistics are from the updated 2012 data files. PRAMS provides surveillance of unintededness in pregnancies that resulted in a live birth. The PRAMS rate of unintendedness alone is an underestimate as it doesn't include pregnancies that resulted in fetal deaths or ITOPS. Beginning with the 2010 data year, the Hawaii measure of unintendedness from PRAMS will be based on 1 question instead of the 2 questions it had been previously based on in prior years that data was reported in Title V to be consistent with how unintendedness is reported by CDC. The values used for the numerator and denominator also changed. Beginning with 2010 the numerator and denominator will use births from Hawai'i Vital Stat instead of the total number of unintended births from PRAMS that was used previously. The numerator will be the sum of births (Vital Statistics) and the number of fetal deaths (Vital Statistics) multiplied by the proportion of unintended births (PRAMS), plus abortions (VItal Statistics). The denominator is the total number of live births (Vital Statistics), fetal deaths (Vital Statistics), and abortions (Vital Statistics). The annual performance objective for the years 2014 to 2018 was carried forward from the 2012 annual indicator which reflected an approximately 5 percent improvement from 2011.

3.	**Field Name:**	**2012**

Field Note:
Data for this measure comes from the Hawai'i Pregnancy Risk Assessment Monitoring Sysytem (PRAMS) and Hawai'i Vital Statictics. Data for the year 2011 is the latest data available from PRAMS. Data from Vital Statistics are from the updated 2011 data files.

PRAMS provides surveillance of unintededness in pregnancies that resulted in a live birth. The PRAMS rate of unintendedness alone is an underestimate as it doesn't include pregnancies that resulted in fetal deaths or ITOPS. Beginning with the 2010 data year, the Hawaii measure of unintendedness from PRAMS will be based on 1 question instead of the 2 questions it had been previously based on in prior years that data was reported in Title V to be consistent with how unintendedness is reported by CDC. The values used for the numerator and denominator also changed. Beginning with 2010 the numerator and denominator will use births from Hawai'i Vital Stat instead of the total number of unintended births from PRAMS that was used previously. The numerator will be the sum of births (Vital Statistics) and the number of fetal deaths (Vital Statistics) multiplied by the proportion of unintended births (PRAMS), plus abortions (VItal Statistics). The denominator is the total number of live births (Vital Statistics), fetal deaths (Vital Statistics), and abortions (Vital Statistics).

The annual performance objective for the years 2013 to 2017 was carried forward from the 2012 annual performance objective, after assessing the 2012 annual indicator.

4.	**Field Name:**	**2011**

Field Note:
Data for this measure comes from the Hawai'i Pregnancy Risk Assessment Monitoring Sysytem (PRAMS) and Hawai'i Vital Statictics. Data for the year 2010 is the latest data available from PRAMS. Data from Vital Statistics are from the updated 2010 data files.

PRAMS provides surveillance of unintededness in pregnancies that resulted in a live birth. The PRAMS rate of unintendedness alone is an underestimate as it doesn't include pregnancies that resulted in fetal deaths or ITOPS. Beginning with the 2010 data year, the Hawaii measure of unintendedness from PRAMS will be based on 1 question instead of the 2 questions it had been previously based on in prior years that data was reported in Title V to be consistent with how unintendedness is reported by CDC. The values used for the numerator and denominator also changed. Beginning with 2010 the numerator and denominator will use births from Hawai'i Vital Stat instead of the total number of unintended births from PRAMS that was used previously. The numerator will be the sum of births (Vital Statistics) and the number of fetal deaths (Vital Statistics) multiplied by the proportion of unintended births (PRAMS), plus abortions (VItal Statistics). The denominator is the total number of live births (Vital Statistics), fetal deaths (Vital Statistics), and abortions (Vital Statistics).

The annual performance objective for the years 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011 annual indicator.

Data Alerts:

None

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

	2011	2012	2013	2014	2015

	2011	2012	2013	2014	2015
Annual Objective	4.0	6.0	6.0	6.0	6.0
Annual Indicator	6.9	6.9	6.9	6.9	
Numerator	1,267	1,267	1,267	1,267	
Denominator	18,437	18,437	18,437	18,437	
Data Source	Hawaii State Department of Health	Hawaii State Department of Health	Hawaii State Department of Health	Hawaii State Department of Health	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Data for this measure comes from the Pregnancy Risk Assessment Monitoring System (PRAMS) and reflects data from births that occurred in the specified year. Data for the year 2011 is the latest available from PRAMS Hawaii and was carried forward to 2012, 2013 and 2014. The annual performance objective for the year 2015 was carried forward from the 2012 annual indicator which reflected an approximately 5 percent improvement from 2011.	
2.	**Field Name:**	**2013**
	Field Note: Data for this measure comes from the Pregnancy Risk Assessment Monitoring System (PRAMS) and reflects data from births that occurred in the specified year. Data for the year 2011 is the latest available from PRAMS Hawaii and was carried forward to 2012 and 2013. The annual performance objective for the years 2014 to 2018 was carried forward from the 2012 annual indicator which reflected an approximately 5 percent improvement from 2011.	
3.	**Field Name:**	**2012**
	Field Note: Data for this measure comes from the Pregnancy Risk Assessment Monitoring System (PRAMS) and reflects data from births that occurred in the specified year. Data for the year 2011 is the latest available data and was carried forward to 2012. The annual performance objective for the years 2013 to 2017 was changed to approximately reflect a 5 percent improvement from the 2011 annual indicator.	
4.	**Field Name:**	**2011**
	Field Note: Data for this measure comes from the Pregnancy Risk Assessment Monitoring System (PRAMS) and reflects data from births that occurred in the specified year. Data for the year 2010 is the latest available data and was carried	

forward to 2011. The annual performance objective for the years 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011 annual indicator.

Data Alerts:

None

SPM 3 - The percentage of parents of children 10 months to 5 years who report completing a standardized developmental and behavioral screener (SDBS) during a health care visit in the past 12 months.

	2011	2012	2013	2014	2015
Annual Objective	29.0	29.0	41.0	41.0	41.0
Annual Indicator	27.2	38.9	38.9	38.9	
Numerator					
Denominator					
Data Source	NSCH Survey	NSCH Survey	NSCH Survey	NSCH Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
The indicator data comes from the U.S. Department of Health and Human Services; Health Resources and Services Administration; Maternal and Child Health Bureau, 2011-2012 National Survey of Children's Health survey conducted by the U.S. Department of Health and Human Services; Centers for Disease Control and Prevention; National Center for Health Statistics. The data from the 2011-2012 National Survey of Children's Health is comparable to the 2007 NSCH survey. The annual performance objective for the years 2014 to 2018 was changed to approximately reflect a 5 percent improvement from the 2012 annual indicator.

2.	**Field Name:**	**2013**

Field Note:
The indicator data comes from the U.S. Department of Health and Human Services; Health Resources and Services Administration; Maternal and Child Health Bureau, 2011-2012 National Survey of Children's Health survey conducted by the U.S. Department of Health and Human Services; Centers for Disease Control and Prevention; National Center for Health Statistics. The data from the 2011-2012 National Survey of Children's Health is comparable to the 2007 NSCH survey.

The annual performance objective for the years 2014 to 2018 was changed to approximately reflect a 5 percent improvement from the 2012 annual indicator.

3.	**Field Name:**	**2012**

Field Note:
The indicator data comes from the U.S. Department of Health and Human Services; Health Resources and Services Administration; Maternal and Child Health Bureau, 2011-2012 National Survey of Children's Health survey conducted by the U.S. Department of Health and Human Services; Centers for Disease Control and Prevention; National Center for Health Statistics. The data from the 2011-2012 National Survey of Children's Health is comparable to the 2007 NSCH survey.

The annual performance objective for the years 2013 to 2017 was changed to approximately reflect a 5 percent improvement from the 2012 annual indicator.

4. **Field Name:** **2011**

Field Note:
The indicator data comes from the U.S. Department of Health and Human Services; Health Resources and Services Administration; Maternal and Child Health Bureau, 2007 National Survey of Children's Health survey conducted by the U.S. Department of Health and Human Services; Centers for Disease Control and Prevention; National Center for Health Statistics.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	7.5	6.5	6.5	6.2	5.9
Annual Indicator	7.0	6.5	6.2	6.2	
Numerator					
Denominator					
Data Source	University of Hawaii; Center on the Family	University of Hawaii; Center on the Family	University of Hawaii; Center on the Family	University of Hawaii; Center on the Family	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

Field Note:
Numerators and Denominators are not available. Data is from the University of Hawaii; College of Tropical Agriculture and Human Resources; Center on the Family. The numerator and denominator data are available from The Center on the Family, but The Center on the Family obtains their information from the Hawaii Department of

Human Services; Social Services Division; Child Welfare Services and from the U.S. Department of Commerce; Bureau of Census. The most recent data available from the Center on the Family is for the year 2013. Data for 2014 was not available at time of this report so data from 2013 was carried to 2014. The annual performance objective for the year 2015 was changed to approximately reflect a 5 percent improvement from the 2013 annual indicator.

2.	**Field Name:**	**2013**

Field Note:
Numerators and Denominators are not available.

Data is from the University of Hawaii; College of Tropical Agriculture and Human Resources; Center on the Family. The numerator and denominator data are available from The Center on the Family, but The Center on the Family obtains their information from the Hawaii Department of Human Services; Social Services Division; Child Welfare Services and from the U.S. Department of Commerce; Bureau of Census. The most recent data available from the Center on the Family is for the year 2012. Data for 2013 was not available at time of this report so data from 2012 was carried to 2013.

The annual performance objective for the years 2014 to 2018 was changed to approximately reflect a 5 percent improvement from the 2012 annual indicator.

3.	**Field Name:**	**2012**

Field Note:
Data source is the University of Hawaii; College of Tropical Agriculture and Human Resources; Center on the Family. The Center on the Family obtains their information from the Hawaii Department of Human Services; Social Services Division; Child Welfare Services and from the U.S. Department of Commerce; Bureau of Census. The most recent data available from the Center on the Family is for the year 2011. Data for 2012 was not available at time of this report so data from 2011 was carried to 2012.

The annual performance objective for the years 2013 to 2017 was changed to approximately reflect a 5 percent improvement from the 2011 annual indicator..

4.	**Field Name:**	**2011**

Field Note:
Data source is the University of Hawaii; College of Tropical Agriculture and Human Resources; Center on the Family. The Center on the Family obtains their information from the Hawaii Department of Human Services; Social Services Division; Child Welfare Services and from the U.S. Department of Commerce; Bureau of Census. The most recent data available from the Center on the Family is for the year 2010. Data for 2011 was not available at time of this report so data from 2010 was carried to 2011. The annual performance objective for the years 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011 annual indicator.
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Data Alerts:

None

SPM 9 - The percentage of youth with special health care needs, 12-17 years of age who received all needed anticipatory guidance for transition to adult health care. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective		37.0	37.0	37.0	37.0
Annual Indicator	34.5	34.5	34.5	34.5	
Numerator					
Denominator					
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The same questions were used to generate this indicator for both the 2005-2006 and 2009-2010 CSHCN surveys, therefore the indicator data from 2011-2014 are comparable to that used for the measure from 2007-2010. The annual performance objective for the years 2013 to 2017 was carried forward from 2012 since no new data was available. The annual performance objective will be reassessed when new data becomes available

2.	**Field Name:**	**2013**

Field Note:
For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The same questions were used to generate this indicator for both the 2005-2006 and 2009-2010 CSHCN surveys, therefore the indicator data from 2011-2014 are comparable to that used for the measure from 2007-2010.

The annual performance objective for the years 2013 to 2017 was carried forward from 2012 since no new data was available. The annual performance objective will be reassessed when new data becomes available.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The same questions were used to generate this indicator for both the 2005-2006 and 2009-2010 CSHCN surveys, therefore the indicator data from 2011-2014 are comparable to that used for the measure from

2007-2010.

The annual performance objective for the years 2013 to 2017 was carried forward from 2012 since no new data was available. The annual performance objective will be reassessed when new data becomes available.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The same questions were used to generate this indicator for both the 2005-2006 and 2009-2010 CSHCN surveys, therefore the indicator data from 2011-2014 are comparable to that used for the measure from 2007-2010.

The annual performance objective for the year 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011 annual indicator.

Data Alerts:

None

SPM 10 - Proportion of children who received dental care in the past year.

	2011	2012	2013	2014	2015
Annual Objective			89.0	74.0	74.0
Annual Indicator		83.9	70.3	70.3	
Numerator					
Denominator					
Data Source		YTS	YRBS	YRBS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
Numerators and denominators are not available. Data from the 2011 Youth Tobacco Survey (YTS) was used to establish a baseline for 2012. Data for 2013 comes from the YRBS Oral Health Measure and is not comparable with the 2012 indicator. There was 8.8% of the YRBS population with missing data. There was no new data for 2014, so the 2013 data was carried forward. Since no new data for 2014 was available, the annual performance objective for the year 2015 was unchanged.

2.	**Field Name:**	**2013**

Field Note:
Numerators and Denominators are not available.

Data from the 2011 Youth Tobacco Survey (YTS) was used to establish a baseline for 2012. Data for 2013 comes from the YRBS Oral Health Measure and is not comparable with the 2012 indicator. There was 8.8% of the YRBS population with missing data.

The annual performance objective for the years 2014 to 2018 reflects a 5 percent improvement from the 2013 annual indicator.

3.	**Field Name:**	**2012**

Field Note:
Data from the 2011 Youth Tobacco Survey (YTS) is used to establish a baseline. It is unclear whether there is data compatibilty to 2013 Hawaii Youth Risk Behavior Survey (YRBS), we will reasses when 2013 YRBS data becomes available.

The annual performance objective for the years 2013 to 2017 reflects a 5 percent improvement from the 2012 annual indicator.

Data Alerts:

None

SPM 11 - Percent of Native Hawaiian and Other Pacific Islander (NHOPI) children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective			21.0	20.0	20.0
Annual Indicator		22.5	21.2	21.4	
Numerator		2,080	2,480	2,356	
Denominator		9,237	11,676	10,997	
Data Source		WIC	WIC	WIC	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:

Numerator & Denominator: Data is from the Hawaii Department of Health; Family Health Services Division; Women, Infants and Children Services Branch. Data for 2013 represents NHOPI children 2 to 5 years old in WIC enrolled from 02/01/2013-7/31/2013. The methodology for 2012 data is similar but excluded terminated certifications and therefore slightly different from 2013 which does not exclude terminated certifications. However, indicators are generally comparable. Data for 2012 reflects WIC children in April 2012 while data for 2013 reflects WIC children enrolled from 2/1/2013-7/31/2013. The annual performance objective for the year 2015 was unchanged.

2.	**Field Name:**	**2013**

Field Note:
Numerator & Denominator: Data is from the Hawaii Department of Health; Family Health Services Division; Women, Infants and Children Services Branch. Data for 2013 represents NHOPI children 2 to 5 years old in WIC enrolled from 02/01/2013-7/31/2013. The methodology for 2012 data is similar but excluded terminated certifications and therefore slightly different from 2013 which does not exclude terminated certifications. However, indicators are generally comparable. Data for 2012 reflects WIC children in April 2012 while data for 2013 reflects WIC children enrolled from 2/1/2013-7/31/2013.

The annual performance objective for the years 2014 to 2018 was changed to approximately reflect a 5 percent improvement from the 2013 annual indicator.

3.	**Field Name:**	**2012**

Field Note:
This is a new measure to reflect the population with the highest rates of overweight and obesity found in WIC data. From 2005-2011, WIC PEDNSS data for children of all race groups were reported as both a state (#8) and national (#14) performance measure. In 2012, Hawaii was asked to separate these two performance measures, so no data was reported in the 2012 application for this measure.

Data represents NHOPI children 2 to 5 years old in WIC in April 2012.

The annual performance objective for the years 2013 to 2017 reflects a 5 percent improvement from the 2012 annual indicator.

Data Alerts:

None

Form 11
Other State Data

State: Hawaii

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: Hawaii

Please click the link below to download a PDF of the State Action Plan Table.
State Action Plan Table