# Maternal and Child Health Services Title V Block Grant

## Hawaii

## FY 2017 Application/ FY 2015 Annual Report

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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, 2016

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) 2017 (October 1, 2016 – September 30, 2017). The FY 2017 application and FY 2015 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

**Executive Summary**

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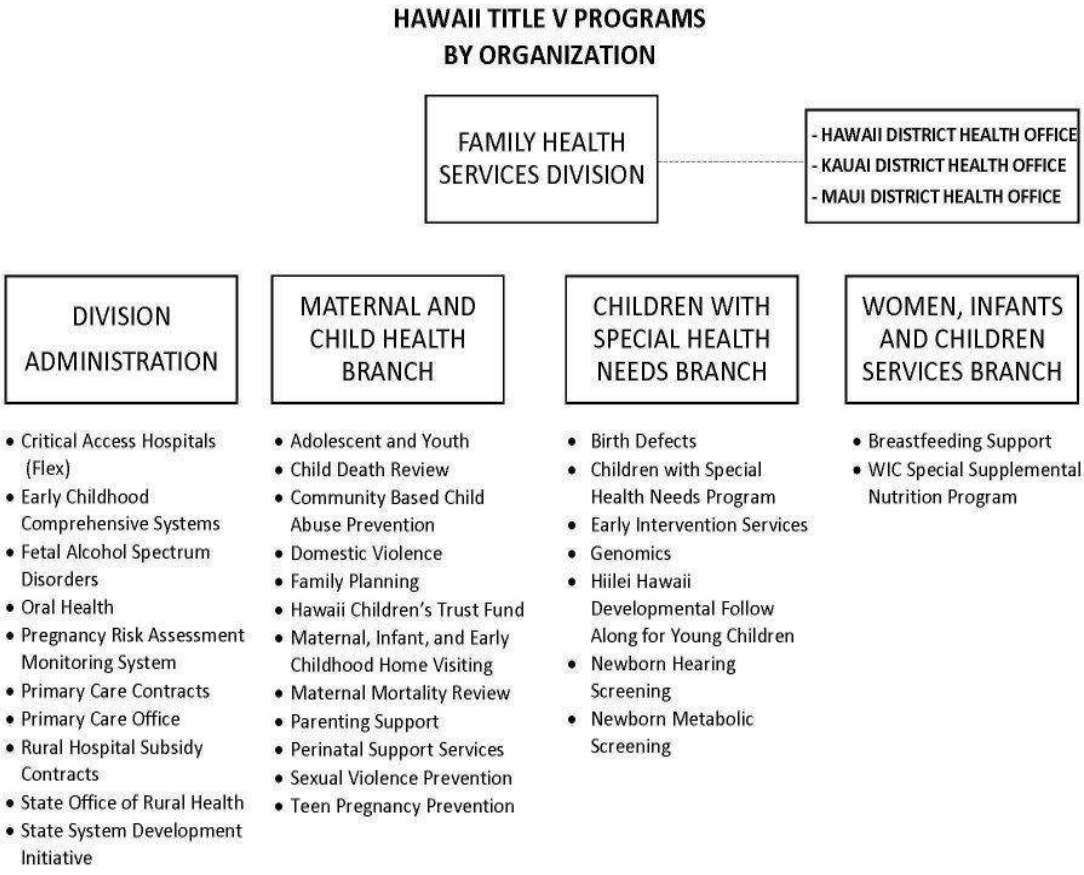



**Hawaii State Title V Five Year Plan**

In 2015, FHSD completed a statewide needs assessment and selected 9 priorities. In 2016, FHSD selected 2 additional priorities on Engaging Families/Consumers and Meaningful Partnerships. Priorities were selected based on:

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

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

| Hawaii State Title V Priorities & Measures for 2016-2020 | | |
|---|---|---|
| **Domain** | **Title V Priority** | **Measure*** |
| Women/ Maternal Health | Promote reproductive life planning | ESM 1.1 – Percent of births with less than 18 months spacing between birth and next conception |
| Perinatal/ Infant Health | Reduce infant mortality through breastfeeding | ESM 4.1 – Percent of WIC infants ever breastfed |
| | Reduce infant mortality through safe sleep | ESM 5.1 – Percent of birthing hospitals with current American Academy of Pediatrics safe sleep protocols |
| Child Health | Improve percentage of children age 0-5 years screened early and continuously for developmental delay | ESM 6.1 – Development and implementation of Data sharing system for FHSD programs conducting developmental screening, referrals, and services |
| | Reduce rate of child abuse and neglect with special attention on ages 0-5 years | ESM 7.1 – Percent of children in a home visiting program with an injury-related visit to the emergency department since enrollment |
| Adolescent Health | Improve the development, health, safety, and well-being of adolescents | ESM 10.1 – Development and dissemination of a teen-centered Adolescent Resource Toolkit (ART) with corresponding continuing education series (Science) to primary care providers to increase knowledge and skills in implementing the adolescent well-care visit |
| Children & Youth with Special Health Care Needs | Promote transition to adult health care | ESM 12.1 – Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult health care for youth with special health care needs |
| Life Course | Improve oral health of children and pregnant women | ESM 13.1 – Establishment of leadership for the State Oral Health Program under the direction of a dental professional and staff with public health skills<br>ESM 13.2 – Completion of teledentistry pilot project at three early childhood settings to reach underserved children and pregnant women |
| | Increase use of telehealth across Title V activities to improve access to services and education for families and providers | SPM 1 – Degree to which Title V programs utilize telehealth to improve access to services and education for families and providers |
| | Improve family and consumer engagement in Title V programs | SPM 2 – Percent of FHSD staff that have increased their knowledge on family/consumer engagement |
| | Improve partner engagement in FHSD | SPM 3 – Percent of FHSD staff that have increased their knowledge on partner engagement |
| | | *ESM = Evidence-based/informed Strategy Measure<br>SPM = State Performance Measure |

**DOMAIN: WOMEN/MATERNAL HEALTH**

***Promote reproductive life planning***

Accomplishments: Hawaii participated in the 2015 Infant Mortality Collaborative Information and Innovative Network (CoIIN) Learning Session and was introduced to One Key Question® (OKQ). This screening approach was integrated into the Hawaii Maternal Infant Health Collaborative (HMIHC) workplan to improve preventive health for reproductive age women. Long acting reversible contraception (LARC) was also adopted as an evidence based

strategy from CoIIN. HMIHC completed an assessment of Medicaid insurance policies reimbursement for LARC placement for post-partum women and developed a Provider Reimbursement Guide on coverage for LARC by Medicaid plans.
Challenges: Acquiring timely data for monitoring project benchmarks. Staffing to oversee activities for the OKQ implementation. Provider barriers to LARC such as insurance coverage of device and on-site proctor insurance training for inexperienced providers.
Plans: Promote preconception health care visit (*e.g.* identify access barriers, community and provider education, public awareness). Promote reproductive life planning (*e.g.* increase birth spacing, improve access to family planning services). Promote healthy behaviors (e.g. smoking cessation, decrease alcohol and substance use, healthy weight, use of folic acid, chronic disease control).

**DOMAIN: PERINATAL/INFANT HEALTH**

***Reduce infant mortality through promoting breastfeeding***

Accomplishments: HMIHC identified breastfeeding promotion as important to improving birth outcomes and reducing infant mortality. WIC provides mothers with education and support and has a Breastfeeding Coordinator. WIC Breastfeeding Peer Counselor Project conducts monthly group sessions for pregnant and breastfeeding WIC moms. WIC participates in the State Breastfeeding Coalition which sponsored a Secrets of Baby Behavior Train the Trainer Workshop on infant-feeding practices.
Challenges: Lack of a Statewide Breastfeeding Coordinator to serve all families, including those not served by WIC. Birthing facilities improving in appropriate use of breastfeeding supplements, inclusion of model breastfeeding policies, hospital discharge planning support, assessing staff competency.
Plans: Strengthen programs that provide mother-to-mother support and peer counseling. Use community organizations to promote and support breastfeeding. Train home visitors and WIC staff to help mothers overcome common breastfeeding challenges. Refer pregnant moms served by FHSD programs to *Text4Baby* information service. Offer *Baby Behavior* Train the Trainer session at birthing facilities.

***Reduce infant mortality through promoting safe sleep***

Accomplishments: HMIHC's strategic plans to reduce infant mortality includes fostering safe sleep practices. In 2015, Safe Sleep Hawaii (supported by Title V MCH Branch) and HMIHC participated in the national CoINN meeting as the Hawaii Safe Sleep Team. The Team efforts to reinstitute Child Death Review (CDR) lead to state law Act 203 (2016) which provides DOH funding for CDR and maternal death reviews. In June 2016 a statewide CDR training was held for stakeholders, staff, and CDR council members.
Challenges: Practice of co-sleeping among local families, which may be related to ethnicity/culture and small or multi-family living arrangements due to high housing costs. Providing safe sleep education that engages parents in making informed decisions on creating a safe environment.
Plans: Review all birthing hospital policies and training needs. Increase infant safe sleep environment knowledge for caregivers. Collect information on co-sleeping beliefs/behaviors among diverse cultures in Hawaii. Integrate safe sleep education into WIC services. Continue safe sleep training of professionals working with new parents. Work with perinatal nurse managers to assess hospital protocols.

**DOMAIN: CHILD HEALTH**

***Promote Developmental Screenings and Services***

Accomplishments: FHSD coordinated with various initiatives, including the Early Learning Action Strategy workgroup to establish a universal screening-referral-utilization system, Collective Impact public/private partnership which included a developmental screening focus, Maternal Infant and Early Childhood Home Visiting which provides developmental screening, and FHSD Developmental Screening Workgroup on internal coordination. Hawaii received federal Early Childhood Comprehensive Systems funding for 2016-2021 to conduct developmental screening of 3-year-olds on Maui island.
Challenges: Need integrated developmental screening system to ensure there are available supports statewide and in each community. Lack of detailed EPSDT data on screening. Need infrastructure support including training and data systems.
Plans: Develop guidelines and toolkit for early childhood providers and health professionals on developmental screening, referral, and services. Work with families and parent organizations to develop family-friendly materials on

the importance of screening. Develop an internal data sharing system for FHSD programs. Develop infrastructure for developmental screening, referral, and services for children in DOH programs.

### *Prevent Child Abuse and Neglect (CAN)*

Accomplishments: FHSD staff participated in an initiative convened by a State Senator to address CAN issues with the intent to increase collaboration across departments. This initiative will assist FHSD to formulate a CAN/child well-being plan for Hawaii. FHSD activities to prevent CAN include Home Visiting services, Parenting Support Program services that utilize CAN prevention protective factors to encourage safe nurturing relationships, and Neighbor Island District Health Office staff co-leading the State's Child Welfare Citizens Review Panel.
Challenges: Improving coordination and collaboration of many CAN prevention and family support assets. With different federal funding streams, there are separate program purposes, reporting, and data collection, even when programs target the same families and communities.
Plans: Raise awareness about importance of safe nurturing relationships to prevent CAN. Improve evaluation capacity of Family Support and Violence Prevention Section programs to assure improved outcomes. Improve communication, coordination, and collaboration between programs addressing child wellness and family strengthening.

## DOMAIN: ADOLESCENT HEALTH

### *Promote Adolescent Well-Being*

Accomplishments: FHSD partnered with Hawaii Maternal Child Health Leadership Education in Neurodevelopmental & Related Disabilities (MCH LEND) program to conduct adolescent focus groups and provider surveys to assist with needs assessment. Hilopaa Family to Family Health Information Center (F2FHIC) (whose Director was MCH LEND Co-Director) completed supplemental interviews and a focus group with primary care providers. F2FHIC remains a critical partner to identify/implement activities for this measure.
Challenges: Securing adequate resources (staff, funding, leadership) to assure progress. Community health care transformation activities may compete for primary care providers' interest and time.
Plans: Partner with key community stakeholders to develop strategies to improve quality of adolescent well care visits (AWCV). Develop messaging to describe value of AWCV. Disseminate medical home materials including the Adolescent Resource Toolkit and consumer materials on adolescent preventive services. Increase resources, training and practice improvement support for adolescent health providers to provide teen-centered, well-care visits aligned to Bright Futures.

## DOMAIN: CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

### *Promote transition to adult health care*

Accomplishments: Following Maui's Big Moving Across the Community Transition Fair, Kauai, Oahu, and Hawaii hosted similar events for youth with special health care needs (YSHCN). Children with Special Health Needs Program (CSHNP) provided Transition to Adulthood education sessions (Kauai); shared transition information at annual parent/special needs conference (Oahu); and worked with Kona Kardiac Kids support group to educate them about transition (Hawaii).
Challenges: Busy families with other priorities. Time to coordinate and organize discussions with and between multiple service providers. Individualizing the transition process with youth input.
Plans: Convene stakeholders including youth to develop strategies to improve services for adolescents/families necessary to transition to adult health care. Develop educational materials with smaller manageable transition steps for younger ages. Promote staff development in transition issues. Collaborate with FHSD/Adolescent Health Program to integrate transition planning into the program's stakeholder networks and service contracts. Promote and/or facilitate transition to adult health care for YSHCN age 14-21 years receiving CSHNP services.

## DOMAIN: CROSS-CUTTING OR LIFE COURSE

### *Improve oral health*

Accomplishments: FHSD has a 5-Year CDC oral health state infrastructure building grant. Efforts have focused on establishing oral health positions, building data surveillance, promoting/piloting evidence-based practices including a pilot school dental sealant project and pilot teledentistry project at three early childhood settings.
Challenges: Difficulty filling the Dental Director and Program Manager positions. This impacted progress in developing a coordinated system of care and promoting evidence-based oral health practices.
Plans: Fill the oral health positions to assure leadership for the state oral health program; continue building oral

health data surveillance, complete environmental scan to inform state planning; pilot evidence-based strategies (i.e. school dental sealant project and promotion of fluoride varnish application by pediatric providers); pilot teledentistry in early childhood settings including Head Start and WIC; and promote coalition-building and partnerships to assure broad participation in state oral health planning.

### *Improve access to services & education through telehealth*

Accomplishments: FHSD is implementing or increasing telehealth activities for genetics, newborn screening, early intervention, and home visiting activities. Telehealth workforce training is being developed. Project ECHO Hawaii utilizes videoconferencing to build primary care workforce capacity while improving patient access to specialty health care in rural communities. FHSD is supporting a pilot teledentistry program on Hawaii island.
Challenges: Programs/staff learning and using new skills and tools for services and education.
Plans: Telehealth infrastructure development–form a FHSD telehealth work group, develop and implement policies/procedures for telehealth, develop network of telehealth sites and personnel.
Workforce development–develop curriculum to train staff on using telehealth, implement and evaluate training to improve curriculum.
Service provision–identify services to be provided using telehealth, pilot programs, expand successful pilot programs.
Education/Training–identify education and training to be provided using telehealth, pilot programs, expand successful pilot programs.

### *Engage families & consumers as partners with FHSD*

Accomplishments: FHSD held Focus Group staff training with information on working with families and listening to their perspective. In 2015, FHSD supported the Parent Leadership Training Institute for parent leaders. Hawaii Directors of Health and Human Services studied the Two-Generation model, and are adopting Ohana Nui ("Extended Family") with a multi-generational approach for engaging families. FHSD recognizes the need to include family and consumer partners for improved health outcomes.
Challenges: Resources to support stipends for parents to attend meetings; schedule staff planning meetings to ensure families/consumers can attend; developing infrastructure and policy to support family and consumer engagement.
Plans: Work together on collaboration, providing awareness and education, and encouraging staff development. Collaboration activities include convene agency and community stakeholders to develop strategies, inventory FHSD program efforts in family/consumer engagement, identify programs that need family/consumer engagement strategy, initiate Plan-Do Study Act cycles for early adopters to evaluate engagement and refine processes, develop FHSD engagement guideline.

### *Increase meaningful partnerships with FHSD*

Accomplishments: In the 2010 FHSD strategic planning, FHSD determined that its primary audience was partners, stakeholders, and contractors. The Title V needs assessment recognized many partners work on similar issues including needs assessments. FHSD recognizes the importance of improving partnerships to improve outcomes for children and families.
Challenges: Defining partners and supporting staff to see the value in partnership development. Critically looking at FHSD programs and how they engage partners; programs seeing value in improving partnerships; staff and partner willingness/time to change and engage.
Plans: Focus on collaboration, education, and staff development. FHSD workforce development on partnership. Work with partners to study and implement the "meaningful partnership continuum". Bring new partners to FHSD programs.

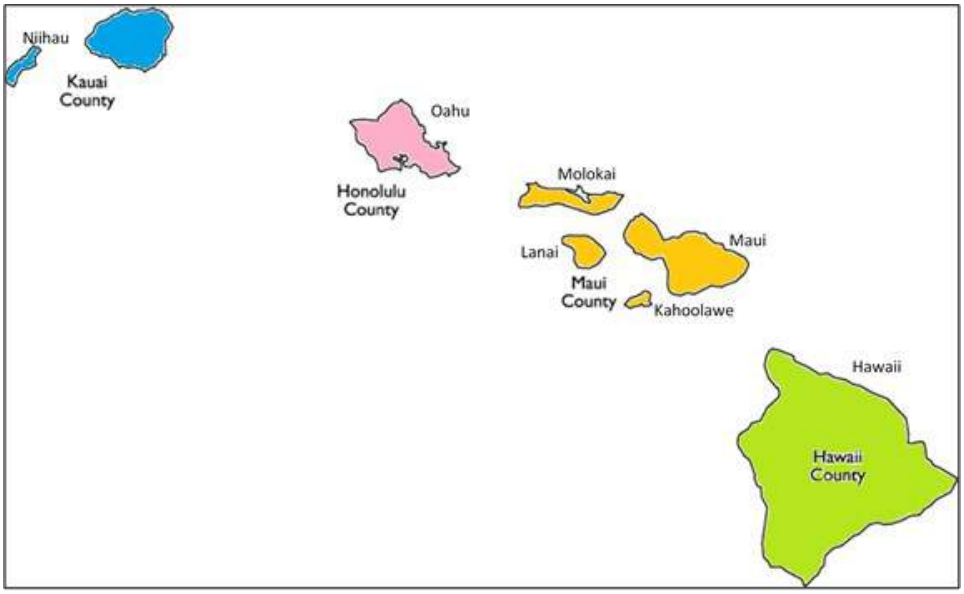
## II. Components of the Application/Annual Report

### II.A. Overview of the State

### GEOGRAPHY

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

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




Approximately 70% of the state population resides in the City and County of Honolulu on the island of Oahu, concentrated in the Honolulu metropolitan area. The neighbor island counties are Hawaii, Kauai (includes Niihau which is privately owned with restricted access) and Maui (includes Molokai, Lanai, and Kahoolawe, 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 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 U.S. Census Bureau, the estimated 2015 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 (69.8%) of the state's population (998,714 residents), while 13.7% live on the Big Island (196,428 residents), 11.5% (164,726 residents) in Maui County, and 5.0% (71,735 residents) in Kauai County. From 2010 to 2015, the U.S. Census Bureau estimated an overall growth in the state of 5.2%: 6.9% on the county of Kauai, 6.3% on the county of Maui, 6.1% on the county of Hawaii, and 4.8% on the city and county of Honolulu.

**ETHNIC DIVERSITY**

Hawaii is one of the most diverse states in the U.S. with no single race majority. In 2010 census data, 23.6% of the population reported two or more races, and the following single race proportions (White=24.7%;Asian=38.6%;Native Hawaiian or Other Pacific Islander(NHOPI)=10.0%;Black=1.6%;and American Indian/Alaskan Native=0.3%). The largest Asian single race sub-groups were Filipino(14.5%), and Japanese(13.6%) and the largest NHOPI single race sub-group was Native Hawaiian(5.9%).

| Race Group | Detailed Sub Groups |
|---|---|
| Asian | Filipino |
| | Japanese |
| | Chinese |
| | Korean |
| | Vietnamese |
| | Asian Indian |
| | Thai |
| | Laotian |
| | Taiwanese |
| | Cambodian |
| | Indonesian |

| | | |
|---|---|---|
| Native Hawaiian or Other Pacific Islander | Polynesian | Native Hawaiian<br>Samoan<br>Tongan<br>Tokelauan<br>Tahitian |
| | Micronesian | Guamanian or Chamorro<br>Marshallese<br>Kosraean<br>Chuukese<br>Palauan<br>Yapese<br>Saipanese<br>I-Kiribati |
| | Melanesian | Fijian<br>Papua New Guinean<br>Ni-Vanuatu<br>Solomon Islander |

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

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

C2010BR-12

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

Due to the large proportion with more than one race, race can be reported as “alone” or “alone or in combination” with another race group. This can have implications as seen in the table with Native Hawaiian accounting for 21.3% of the state population when reported as “alone or in combination,” compared to just 5.9% when Native Hawaiian is reported singly. Those that report two or more race groups are not included in the single race groups commonly reported.

**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 2014, an estimated 25.2% spoke a language other than English at home (9th highest state ranking), compared to 21.1% nationally. An estimated 12.8% of Hawaii residents reported limited English proficiency (4th highest state ranking), compared to 8.6% nationally. The most common languages spoken at home other than English include Other Pacific Island languages (111,515), Tagalog (58,197), Japanese (45,621), Chinese (32,054), and Spanish (26,779) followed by Korean (18,079) and Vietnamese (8,201). (ACS 2011-2013 estimates)

In School Year 2014-2015, 7% (12,144) of the state's public school students were enrolled in English Language Learner Program. The top five languages spoken by Hawaii public school students are Ilokano, Chuukese, Marshallese, Tagalog, and Spanish.

**Compact of Free Association (COFA)**

In Hawaii there is a growing concern over the impact of COFA migrants that includes Federated States of Micronesia, Republic of Marshall Islands, and Republic of Palau. Under the compact, COFA migrants are designated as legally residing noncitizen nationals who 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 (tuberculosis, Hansen’s disease/leprosy), and other medical concerns (which may be

related to U.S. nuclear tests conducted in the Pacific nations) with additional challenges due to substantial language and cultural barriers within the COFA population. In 2014, the social, health, educational, and welfare system costs attributed to the estimated 14,700 COFA migrants in Hawaii was $163 million dollars. Estimates indicate roughly 1,000 migrants are homeless. Migrants account for about 2-3% (400-600) births annually in Hawaii, with low rates of prenatal care utilization, high rates of low birth weight, and recent concerns about high rates of NICU admissions.

**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 Tripler Army Medical Center is the only federal tertiary care hospital in the Pacific Basin. It supports 264,000 local active duty and retired military personnel, their families, and veteran beneficiaries. Medical services are also available on 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, including 24.8% (1,896) 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.

**Maternal and Child Population**

Based on 2014 Census data, the state population of Hawaii increased about 4.4% to 1,419,561 residents compared to 2010 when the population was 1,360,301 with the overall median age changing from 38.6 years in 2010 to 37.9 years in 2014.

In 2014, there were 267,712 women of reproductive age (defined as women 15-44 years old) which represents a small 2.1% increase from the 2010 census data of 262,107. This group represents about 18.9% of the entire state population.

During the last 24 years, the number of births in Hawaii 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 2014, there were 177,763 children 9 years of age or younger in Hawaii, which represents a 4.1% increase from 2010 when there were 170,768. This group represents 12.5% of the state population.

In 2014, there were 162,896 children 10-19 years of age in Hawaii, which represents a 2.8% decrease from 2010 when there were 167,533. This group represents 11.5% of the state population.

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

**Older Population**

Hawaii's population, like the U.S. as a whole, is aging. In 2014, persons age 65 years and over comprised 16.1% of the population, compared to 14.3% in 2010. Nationwide, this population comprised 14.5% in 2014, compared to 13.0% in 2010.

**ECONOMY**

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

**Economic Growth**

According to the State Department of Business, Economic Development and Tourism (DBEDT) second quarter 2016 outlook, Hawaii's economy is expected to continue positive growth for the rest of 2016 and into 2017. This outlook is based on the most recent developments in the national and global economies, the performance of Hawaii's tourism industry, labor market conditions, and the growth of personal income and tax revenues. 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 $49,686 in 2014 (in 2009 dollars), $217 or 0.4% higher than the U.S. average. Hawaii ranked 21st among the 50 states.

**Unemployment**

Hawaii unemployment rates reflect the state's economic recovery. The state's unemployment rate peaked at 7.4% after the recession with a record 47,000 individuals unemployed. According to the Bureau of Labor Statistics, the annual average unemployment rate in Hawaii was 4.4% in 2014, 1.8% point lower than the U.S. average of 6.2%. Hawaii ranked 9th lowest among the 50 states.

**State Budget**

In May 2016, the State Council on Revenues lowered its forecast for growth in the State General Fund tax revenue in FY 2016 from 6.7% to 6.1%. The Council retained the forecast for growth rates at 5.0% for FY 2017 through FY 2019. The Council noted that Hawaii's economy continues to be strong, but expressed uncertainty about the recent declining trend in General Fund tax revenues. They did note that the economic data, including visitor arrivals and expenditures, job counts, and construction activities, are growing at a stronger rate than the Council's forecasts.

**Tourism**

Overall, 2015 was another record breaking year for tourism with 8.65 million travelers coming to the islands and visitor expenditures of $15.2 billion. Although vulnerable to changing markets and trends, in 2016, forecasters expect visitor arrivals will increase 2.2% and visitor expenditures will increase 2.5%

**Poverty**

Hawaii's poverty rate in 2014 was 11.4% (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 (FPL). Like unemployment rates, poverty rates are variable across counties: Honolulu 9.8%; Maui 13.1%; Kauai 12.3%; and Hawaii 18.1%.

The official poverty rate ranks Hawaii as the 7$^{th}$ lowest in the nation. However, the official FPL obscures the struggles faced by many families in Hawaii because of the high cost of living in the state and the generally low wage structure given the dependence of service industry jobs in tourism. The Census supplemental poverty rate (which considers factors such as the cost of living, entitlements) for 2011-2013 for Hawaii was 18.4%, 5th highest in the U.S.

**Wages**

According to the Bureau of Labor Statistics, average annual wages for employees in Hawaii was $45,210 in 2014, $6,154 or 12% lower than the U.S. average of $51,364. Hawaii ranked 27th among the 50 states. Among private sector employees only, the situation is worse. Average annual wages for employees in the private sector was $42,583 in 2014, $8,713 or 17.0% 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.

In April 2016, the median housing cost for a single family dwelling on Oahu was $720,000 and for a condominium was $389,500 (Honolulu Board of Realtors). The median monthly owner mortgage cost in 2014 was $2,173, $719 or 49.4% higher than the U.S. average. Among these homeowners, 31.7% spent *35% or more of their household income*, which was higher than the U.S. average of 23.4%. Hawaii ranked the highest in the nation for this indicator. Not surprisingly, the homeownership rate in Hawaii in 2014 was one of the lowest in the U.S. (47th among the 50 states) at 56.7%, which was lower than the U.S. average of 63.1%.

### Rental Costs

Even for working families, the high cost of fair market rent is out of reach. 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 in 2014 was $1,448, $514 or 55.0% higher than the U.S. average of $934. Hawaii had the highest cost among the 50 states.

### Multi-generational Households

Another consequence of high housing costs is the high number of multigenerational households. In 2014, the percentage of multigenerational family households among all family households in Hawaii was 11.3%, which was higher than the U.S. average of 5.8%. Hawaii had the highest rate among the 50 states.

### Cost of Health Insurance

Health insurance premiums continue to increase annually and can comprise a significant amount of an individual or family’s budget. According to the 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 (ACA) on individuals and family budgets/expenses has yet to be determined.

## HEALTH INSURANCE & HEALTHCARE REFORM

Hawaii has supported the 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 FPL. 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 Hawaii 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. All enrollment for ACA coverage is now through HealthCare.gov. Open enrollment for 2016 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 FPL.

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

In 1996, economic changes led to a tightening of QUEST eligibility. The income requirement was changed from 200 percent of the 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 FPL 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 its 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 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 significant 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 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 COFA 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 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, Women Infants and Children (WIC) Services, 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 FHSD Chief, Danette Wong Tomiyasu was appointed to serve as the new DOH Deputy for Health Resources Administration. The FHSD Chief position is under recruitment, but has been vacant since January 2015.

**STATE DEPARTMENT OF HEALTH: CURRENT PRIORITIES & INITIATIVES**

The new Director of Health, Dr. Virginia "Ginny" Pressler, was appointed director by Governor David Ige in 2014. In an effort to support continuity from previous administrations, Dr. Pressler continued to use the DOH Strategic Plan, "Five Foundations for Healthy Generations, FY2011-2014." The Five Foundations were built around the pillars of: Health Promotion and Disease Prevention, Clean & Sustainable Environments, Health Equity, Quality & Service Excellence, and Emergency Preparedness.

In 2016, efforts to craft a new strategic plan began by the Director through the Office of Policy, Planning, and Program Development (OPPPD). The Strategic Map: 2015 – 2018 will be focusing "Health in All Policies" as an approach to address the social determinants of health that are key drivers of health outcomes and health inequities. This new plan depicts the challenge of the Department to "Make Health Hawaii's Shared Value" which will:

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

There are three strategic priorities which frames the work of respective programs within the department: A. Invest in Healthy Babies and Families; B. Take Health Where People Live, Work, Learn, and Play; and C. Create a Culture of Health throughout Hawaii.

The majority of the strategies and activities in Title V Maternal and Child Health fall into the DOH Strategic Plan Strategic Priority A: Invest in Healthy Babies and Families. This synergy allows for greater collaboration and focused concentration on the broader maternal and child health priorities.

| Title V Domains | DOH Strategic Plan | Title V Priorities |
|---|---|---|
| Women's/Maternal Health | Reduce substance use and exposure for expectant mothers | Promote Screening, Brief Intervention, and Referral to Treatment (SBIRT) for expecting mothers. |
| Women's/Maternal Health | Decrease unintended pregnancies | Promote reproductive life planning |
| Perinatal/Infant Health | Improve post-partum care for moms, dads and baby | Reduce the rate of hospitalization to non-fatal injuries among children 0-9 years and adolescents 10-19 years |
| Perinatal/Infant Health | Increase rates of breastfeeding | Reduce the rate of infant mortality by improving breastfeeding rates |
| Child Health | Assure access to universal health and developmental screenings | Improve the percentage of children screened early and continuously age 0-5 years for developmental delay |
| Child Health | Better understand conditions contributing to child deaths and maternal mortality | Reduce the rate of infant mortality |
| Children with Special Health Care Needs | Improve life prospects for vulnerable and disabled persons | Improve the percentage of youth with special health care needs ages 14-21 years who receive services necessary to make transitions to Adult Health Care |
| Adolescent Wellness | Plan for a system of care for adolescents that addresses physical and emotional health | Improve the healthy development, health, safety, and well-being of adolescents |
| Cross-Cutting | Maximize adoption of telehealth as a community standard of care | Improve access to services through telehealth |

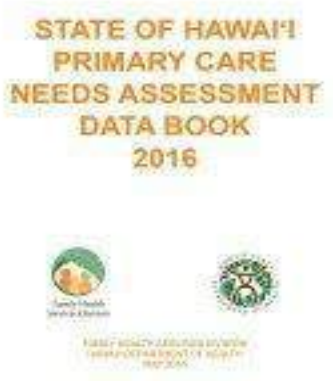
Hawaii received a technical assistance grant from Association of Maternal and Child Health Programs (AMCHP) to better communicate the outcomes from the alignment of efforts between the DOH Strategic Plan and Title V Priorities.

## II.B. Five Year Needs Assessment Summary

### Needs Assessment Update (as submitted with the FY 2017 Application/FY 2015 Annual Report)

### II.B.1. PROCESS

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




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

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

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

**Special studies –** See Oral health/Hawaii Smiles below.

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

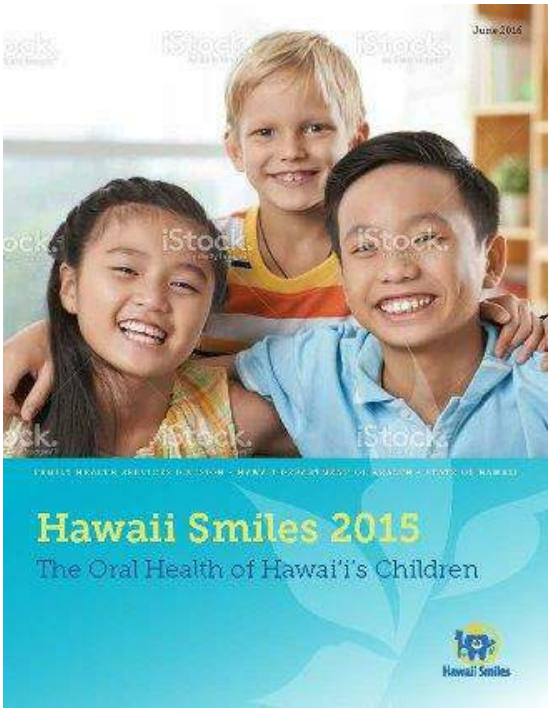
race subgroups.

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

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

**II.B.2. FINDINGS**

**II.B.2.a. MCH POPULATION NEEDS**




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

**Child well-being:** The *2016 KIDS COUNT Data Book* showed that Hawaii ranks 23rd in the US in overall child well-being. Hawaii data showed improved rates for health (low-birthweight babies, children without health insurance,

child/teen deaths, teens who abuse alcohol or drugs). However, rates worsened for economic well-being (poverty, parental employment, teen not in school/not working), education (young children not in school), and family/community (single-parent families, living in high-poverty areas).

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

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

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

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

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

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

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

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

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

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

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

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

**Partnership with other DOH agencies:**

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

**Partnership with other state agencies:**

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

**Public-private partnerships:**

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

**New need–engaging partners:**

In 2010, a new FHSD Chief, Danette Wong Tomiyasu, was hired and FHSD leadership underwent strategic planning. Through an intensive seven-month process, FHSD determined that its primary audience was not families, but instead was partners, stakeholders, and contractors. FHSD did an environmental scan of its contractors and key partners and determined that partnership is a FHSD strength. In general, FHSD recognizes that it cannot do the work alone and its role as a public health leader is to cultivate, honor, and respect partnerships for improved outcomes for children and families. This led to a revised mission statement, where FHSD is a "progressive leader committed to quality health for the families and communities of Hawaii." FHSD achieves this mission through: quality integrative programs, partner development, operational effectiveness, workforce development. FHSD initially prioritized operational effectiveness and workforce development. In 2015, attention turned towards integration and partnership development. Before becoming good partners to those outside FHSD, a focus was on ensuring colleagues within FHSD recognized the importance of partnership and that the Title V needs assessment was the first step in recognizing that many partners were already working on similar issues and doing their own needs assessments. By selecting Partner Engagement as a State priority, Hawaii will address improving relationships with partners to ensure meaningful outcomes for children and families.

**New need–engaging families:**

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

changing health care environment.

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

### II.B.1. Process

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

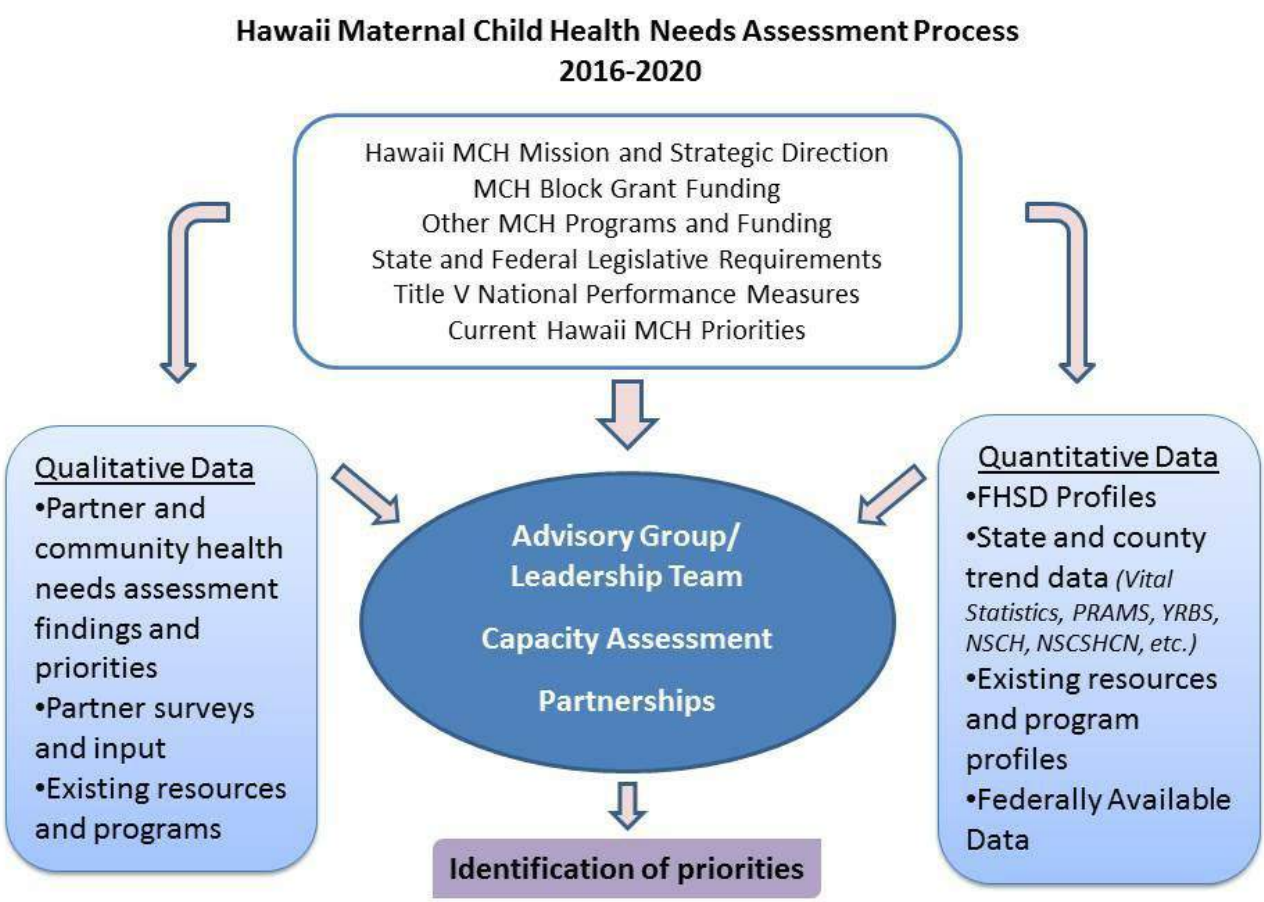
**GOALS, FRAMEWORK, AND METHODOLOGY**

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

The needs assessment framework included:

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

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




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

**STAKEHOLDER INVOLVEMENT**

Stakeholder input was obtained in several ways:

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

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

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

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

**QUANTITATIVE AND QUALITATIVE METHODS**

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

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

**DATA SOURCES**

Sources of quantitative data included:

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

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

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

- **National Immunization Survey** (NIS)

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

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

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

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

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

- **State Inpatient Databases** (SID)

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

Sources of qualitative data included:

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

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

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

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

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

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

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

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

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

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

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

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

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

**INTERFACE BETWEEN NEEDS ASSESSMENT, TITLE V PRIORITY ISSUES, AND ACTION PLAN**
The Needs Assessment led to identifying Title V priority issues for which the Action Plan was developed.
Process:

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

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

3. Needs Assessment with review of MCH issues.

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

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

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

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

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

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

### II.B.2. Findings

#### II.B.2.a. MCH Population Needs

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

**WOMEN/MATERNAL HEALTH**

**Reproductive Life Planning/Unintended Pregnancies**

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

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

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

*FHSD Resources:* FPP, Perinatal Support Services, Home Visiting Network, and WIC Branch include services that support women during the interconception period, including reducing future unintended pregnancies. FHSD participants on the Hawaii MIH Collaborative include Women's and Reproductive Health Section, WIC Branch, and MCH Epidemiologist.

*Community Alignment:* State of Hawaii Community Health Needs Assessment identified family planning as one of the 10 highest ranked indicators reflecting local priorities. It noted that family planning is a need for particular groups, primarily low-income families. Hawaii MIH Collaborative's strategic plan includes promoting reproductive life planning. Healthy Mothers Healthy Babies Coalition of Hawaii/Perinatal Advocacy Network includes a focus to improve use of contraception to prevent unintended pregnancy. State Health Improvement Plan (draft) includes reproductive life planning.

***Hawaii Title V priority issue? – Met all criteria.***

**Preventive Health Visits:** Preventive health visits help women to adopt or maintain healthy habits and behaviors, detect early and treat health conditions, plan for a healthy pregnancy, and consider reproductive life planning.

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

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

*FHSD Resources:* Same as for Unintended Pregnancies above.

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

***Hawaii Title V priority issue? – Met all criteria.***

**Low Risk Cesarean Deliveries**

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

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

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

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

*Community Alignment:* Hawaii MIH Collaborative's strategic plan includes promoting appropriate timing

and method of delivery, including reducing early elective deliveries and decreasing primary cesarean deliveries. State Health Improvement Plan (draft) includes reducing elective deliveries and decreasing primary cesarean sections.

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

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

**PERINATAL/INFANT HEALTH**

**Infant Mortality**

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

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

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

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

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

***Hawaii Title V priority issue? – Met all criteria.***

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

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

For infants who are breastfed exclusively through 6 months, the Hawaii rate (26.4%) is higher than the national rate (18.8%). Lower rates are associated with household income-poverty ratio <100% (21.0%), unmarried status (20.7%), race/ethnicity Hispanic (17.0%) and non-Hispanic multiple race (19.9%), and rural residence (19.6%). (Data source FAD/NIS 2011)

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

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

Home Visiting Network promotes breastfeeding through health education and information during and after pregnancy.

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

***Hawaii Title V priority issue? – Met all criteria.***

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

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

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

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

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

***Hawaii Title V priority issue? – Met all criteria.***

**Perinatal Regionalization**

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

*Data:* Federally Available Data are not available.

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

*FHSD Resources:* Limited.

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

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

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

**CHILD HEALTH**

**Developmental Screening**

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

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

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

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

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

***Hawaii Title V priority issue? – Met all criteria.***

**Child Abuse and Neglect Prevention**

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

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

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

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

*Community Alignment:* Early Childhood Action Strategy includes Nurturing and Safe Families, which has objectives to identify family strengthening supports and services, develop family strengthening core competencies and trainings for early childhood practitioners, and advance family strengthening public awareness and community engagement. Child Care and Development Block Grant, administered by Department of Human Services, has health and safety requirements (including prevention of shaken baby

syndrome and abusive head trauma) for child care providers. State Health Improvement Plan (draft) includes Child Abuse and Neglect Prevention.

***Hawaii Title V priority issue? – Met all criteria.***

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

*Data:* For children ages 0-9 years for hospitalization for non-fatal injury, the Hawaii rate (149.1 per 100,000) is lower than the national rate (166.4). Higher Hawaii rates are associated with age <1 year (182.3) and 1-4 years (168.9), race/ethnicity non-Hispanic Asian/Pacific Islander (300.3) and Non-Hispanic White (178.5), and males (161.6).

For adolescents age 10-19 years for hospitalization for non-fatal injury, the Hawaii rate (212.4) is lower than the national rate (249.9). Higher Hawaii rates are associated with age 15-19 years (290.8), race/ethnicity non-Hispanic Asian/Pacific Islander (323.6) and non-Hispanic white (382.1), and males (272.5). (Data source: FAD/SID 2012)

*FHSD Role:* Family Support and Violence Prevention Section has a role related to non-fatal injuries due to child abuse and neglect that result in hospitalization.

*FHSD Resources:* See resources for Child Abuse and Neglect Prevention.

*Community Alignment:* DOH Injury Prevention and Control Section is the lead agency for injury prevention throughout the state for all age groups. Hawaii Injury Prevention Plan, 2012-2017, includes recommendations for violence and abuse prevention.

***Hawaii Title V priority issue? – Met all criteria.***

**Physical Activity**

Regular physical activity is essential in improving the health and quality of life for children and adolescents. It can reduce the risks for cardiovascular disease, hypertension, type 2 diabetes, and osteoporosis later in life.

*Data:* For children age 6-11 years with physical activity at least 60 minutes per day, the Hawaii rate (39.2%) is higher than the national rate (35.6%). For adolescents age 12-17 years, the Hawaii rate (18.3%) is lower than the national rate (20.5%). (Source: FAD/NSCH 2011/12)

*FHSD Role:* FHSD does not have a lead role, but works on this issue as part of early childhood and adolescent wellness.

*FHSD Resources:* Limited. ECCS Coordinator is co-lead for the Early Childhood Action Strategy on On-track Health and Development workgroup, which is developing Early Childhood Health and Wellness Guidelines which include physical activity. The Adolescent Coordinator is the lead for adolescent well-being.

*Community Alignment:* DOH Chronic Disease Prevention and Health Promotion Division is the lead for Physical Activity and Nutrition (Hawaii Health Initiative). Hawaii Physical Activity and Nutrition Plan 2013-2020 includes objectives regarding comprehensive Health and Physical Education in Department of Education (DOE) schools, and includes physical activity in child care license requirements and wellness guidelines. Hawaii Coordinated Chronic Disease Framework has an objective that educational settings establish comprehensive policies and environments that include supporting daily physical activity for all students.

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

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

**ADOLESCENT HEALTH**

**Adolescent Well-Visit**

Preventive health visits help adolescents adopt or maintain healthy habits and behaviors, manage their health

and health care, manage chronic conditions, and plan their transition to adult health care.

*Data:* For adolescents age 12-17 years with a preventive medical visit in the past year, the Hawaii rate (82.2%) is similar to the national rate (81.7%). Lower Hawaii rates are associated with birth outside U.S. (74.7%) and rural residence (75.9%). (Data source: FAD/NSCH 2011/12)

*FHSD Role:* The Adolescent Coordinator is the lead on this issue.

*FHSD Resources:* Children and Youth with Special Health Needs Section will work with the Adolescent Coordinator on this area, as improving the rates for adolescent well-visits may also impact rates for transition to adult health care.

*Community Alignment:* AAP-Hawaii Chapter priorities for 2015 and beyond include adolescent well care visits with mental health screening annually from age 11 to 21 years.

***Hawaii Title V priority issue? – Met all criteria.***

**Bullying**

Bullying experiences are associated with behavioral and emotional problems for both those who bully or are victims of bullying. Problems may continue into adulthood and may have long-term impact.

*Data:* For adolescents age 12-17 years who are bullied or who bully others, FAD/NSCH 2011/12 data show that the Hawaii rate (15.4%) was comparable to the national rate (14.2%). The FAD/YRBSS 2013 Hawaii rate (25.8%) was also comparable to the national rate (25.2%).

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

*FHSD Resources:* Limited.

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

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

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

**CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS**

**Transition to Adult Health Care**

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

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

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

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

*Community Alignment:* AAP-Hawaii Chapter priorities for 2015 and beyond include transition of adolescents to adult care with a focus on youth with special health care needs. Hilopaa F2FHIC provides education and developed materials to support the transition to adult health care. Transition fair planning has

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

***Hawaii Title V priority issue? – Met all criteria.***

**Medical Home**

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

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

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

*FHSD Resources:* FHSD resources are program-specific. Newborn Metabolic Screening and Newborn Hearing Screening Programs support the medical home by helping to identify newborns who require follow-up and coordination of referrals and services. Early Intervention Section invites the child's medical home providers to Individual Family Support Plan meetings. Genetics Program supports the medical home by increasing access to genetic services in the community, offering outreach clinics to Neighbor Islands and providing telegenetics activities.

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

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

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

**CROSS-CUTTING OR LIFE COURSE**

**Oral Health**

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

*Data:* For women who had a dental visit during pregnancy, the Hawaii rate (42.5%) is lower than the national

rate (50.3%). Lower Hawaii rates are associated with education/high school graduate (30.9%), Medicaid insurance (22.2%), unmarried status (29.0%), maternal age 20-24 years (29.3%), race/ethnicity Hispanic (34.3%) and non-Hispanic Native Hawaiian/Other Pacific Islander (33.9%) (Data source: FAD/PRAMS, 2012).

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

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

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

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

***Hawaii Title V priority issue? – Met all criteria.***

**Access to Services through Telehealth**

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

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

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

*FHSD Resources:* FHSD staff can work with University of Hawaii and Pacific Basin Telehealth Resource Center to maximize resources (broadband connections, equipment, training, technical assistance) available and apply for additional funding if needed. Policies and procedures for implementing HIPAA compliance and evaluation methods are already available for telehealth activities. Early Intervention Section is interested in providing tele-early intervention services.

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

***Hawaii Title V priority issue? – Met all criteria.***

**Smoking**

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

*Data:* FAD data for Hawaii on the percent of women who smoke during pregnancy is not available. For children who live in households where someone smokes, the Hawaii rate (25.7%) is slightly higher than the national rate (24.1%). (Data source: FAD/NSCH 2011/12)

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

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

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

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

**Adequate Insurance Coverage**

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

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

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

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

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

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

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

**SUMMARY OF HAWAII TITLE V PRIORITY ISSUES**

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

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

- Improve access to services through telehealth

### II.B.2.b Title V Program Capacity

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

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

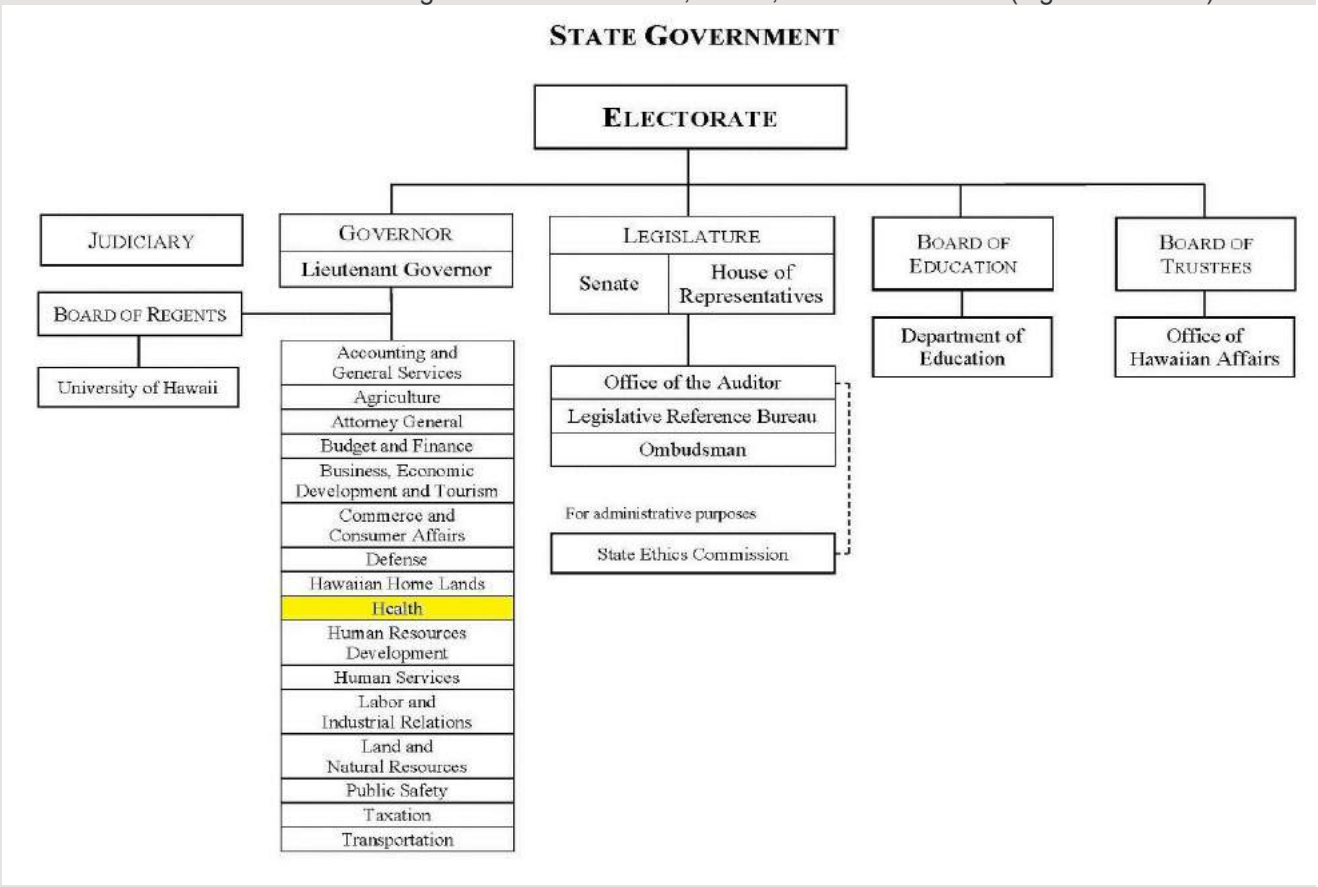



Figure 1

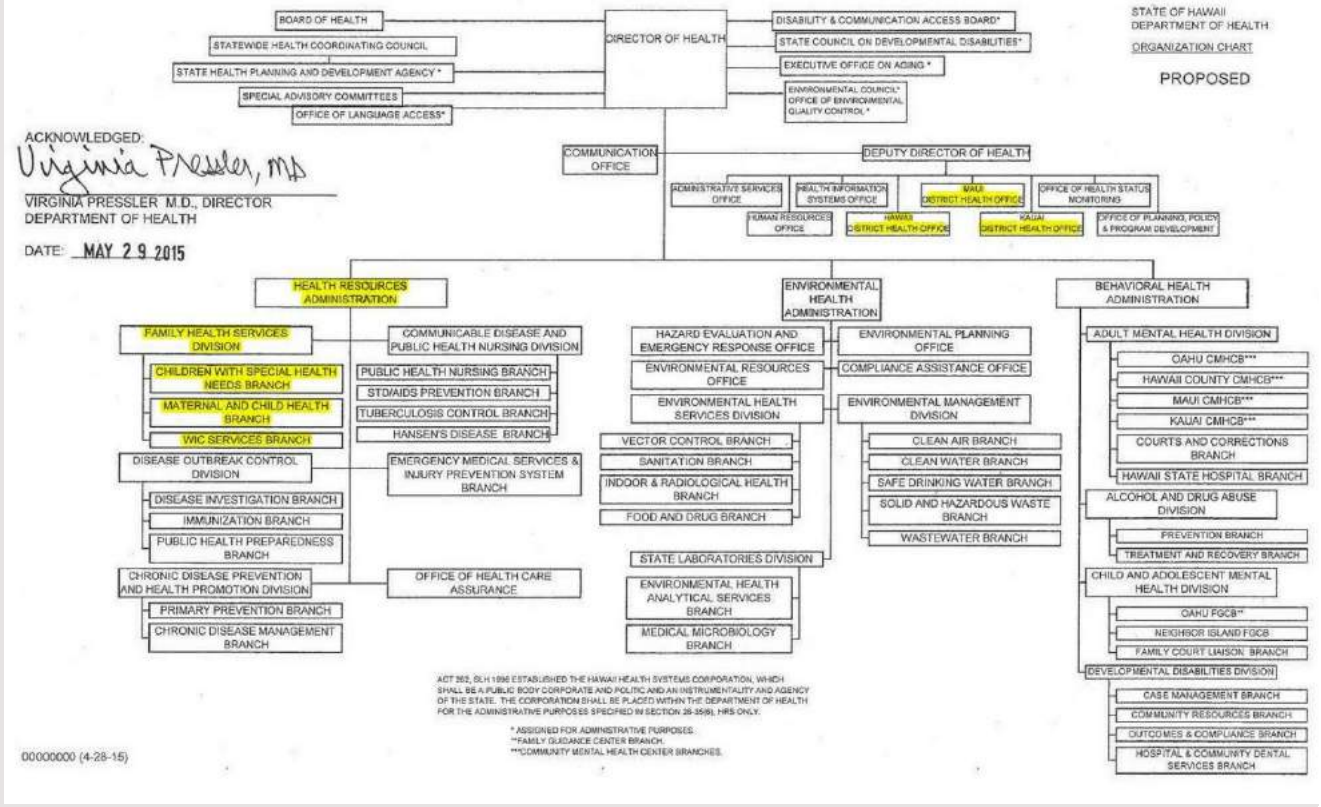

STATE OF HAWAII
DEPARTMENT OF HEALTH
ORGANIZATION CHART
PROPOSED
BOARD OF HEALTH
STATEWIDE HEALTH COORDINATING COUNCIL
STATE HEALTH PLANNING AND DEVELOPMENT AGENCY *
SPECIAL ADVISORY COMMITTEES
OFFICE OF LANGUAGE ACCESS*
DIRECTOR OF HEALTH
DISABILITY & COMMUNICATION ACCESS BOARD*
STATE COUNCIL ON DEVELOPMENTAL DISABILITIES*
EXECUTIVE OFFICE ON AGING *
ENVIRONMENTAL COUNCIL*
OFFICE OF ENVIRONMENTAL QUALITY CONTROL*
ACKNOWLEDGED:
Virginia Pressler, MD
VIRGINIA PRESSLER M.D., DIRECTOR
DEPARTMENT OF HEALTH
DATE: MAY 29 2015
COMMUNICATION OFFICE
DEPUTY DIRECTOR OF HEALTH
ADMINISTRATIVE SERVICES OFFICE
HEALTH INFORMATION SYSTEMS OFFICE
MAUI DISTRICT HEALTH OFFICE
OFFICE OF HEALTH STATUS MONITORING
HUMAN RESOURCES OFFICE
HAWAII DISTRICT HEALTH OFFICE
KAUAI DISTRICT HEALTH OFFICE
OFFICE OF PLANNING, POLICY & PROGRAM DEVELOPMENT
HEALTH RESOURCES ADMINISTRATION
FAMILY HEALTH SERVICES DIVISION
CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH
MATERNAL AND CHILD HEALTH BRANCH
WIC SERVICES BRANCH
DISEASE OUTBREAK CONTROL DIVISION
DISEASE INVESTIGATION BRANCH
IMMUNIZATION BRANCH
PUBLIC HEALTH PREPAREDNESS BRANCH
CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION DIVISION
PRIMARY PREVENTION BRANCH
CHRONIC DISEASE MANAGEMENT BRANCH
COMMUNICABLE DISEASE AND PUBLIC HEALTH NURSING DIVISION
PUBLIC HEALTH NURSING BRANCH
STD/AIDS PREVENTION BRANCH
TUBERCULOSIS CONTROL BRANCH
HANSEN'S DISEASE BRANCH
EMERGENCY MEDICAL SERVICES & INJURY PREVENTION SYSTEM BRANCH
OFFICE OF HEALTH CARE ASSURANCE
ENVIRONMENTAL HEALTH ADMINISTRATION
HAZARD EVALUATION AND EMERGENCY RESPONSE OFFICE
ENVIRONMENTAL RESOURCES OFFICE
ENVIRONMENTAL HEALTH SERVICES DIVISION
VECTOR CONTROL BRANCH
SANITATION BRANCH
INDOOR & RADIOLOGICAL HEALTH BRANCH
FOOD AND DRUG BRANCH
STATE LABORATORIES DIVISION
ENVIRONMENTAL HEALTH ANALYTICAL SERVICES BRANCH
MEDICAL MICROBIOLOGY BRANCH
ENVIRONMENTAL PLANNING OFFICE
COMPLIANCE ASSISTANCE OFFICE
ENVIRONMENTAL MANAGEMENT DIVISION
CLEAN AIR BRANCH
CLEAN WATER BRANCH
SAFE DRINKING WATER BRANCH
SOLID AND HAZARDOUS WASTE BRANCH
WASTEWATER BRANCH
BEHAVIORAL HEALTH ADMINISTRATION
ADULT MENTAL HEALTH DIVISION
OAHU CMHCB***
HAWAII COUNTY CMHCB***
MAUI CMHCB***
KAUAI CMHCB***
COURTS AND CORRECTIONS BRANCH
HAWAII STATE HOSPITAL BRANCH
ALCOHOL AND DRUG ABUSE DIVISION
PREVENTION BRANCH
TREATMENT AND RECOVERY BRANCH
CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
OAHU FGCB**
NEIGHBOR ISLAND FGCB
FAMILY COURT LIAISON BRANCH
DEVELOPMENTAL DISABILITIES DIVISION
CASE MANAGEMENT BRANCH
COMMUNITY RESOURCES BRANCH
OUTCOMES & COMPLIANCE BRANCH
HOSPITAL & COMMUNITY DENTAL SERVICES BRANCH
ACT 262, SLH 1996 ESTABLISHED THE HAWAII HEALTH SYSTEMS CORPORATION, WHICH SHALL BE A PUBLIC BODY CORPORATE AND POLITIC AND AN INSTRUMENTALITY AND AGENCY OF THE STATE. THE CORPORATION SHALL BE PLACED WITHIN THE DEPARTMENT OF HEALTH FOR THE ADMINISTRATIVE PURPOSES SPECIFIED IN SECTION 26-35(6), HRS ONLY.
* ASSIGNED FOR ADMINISTRATIVE PURPOSES.
** FAMILY GUIDANCE CENTER BRANCH.
*** COMMUNITY MENTAL HEALTH CENTER BRANCHES.
00000000 (4-28-15)

Figure 2

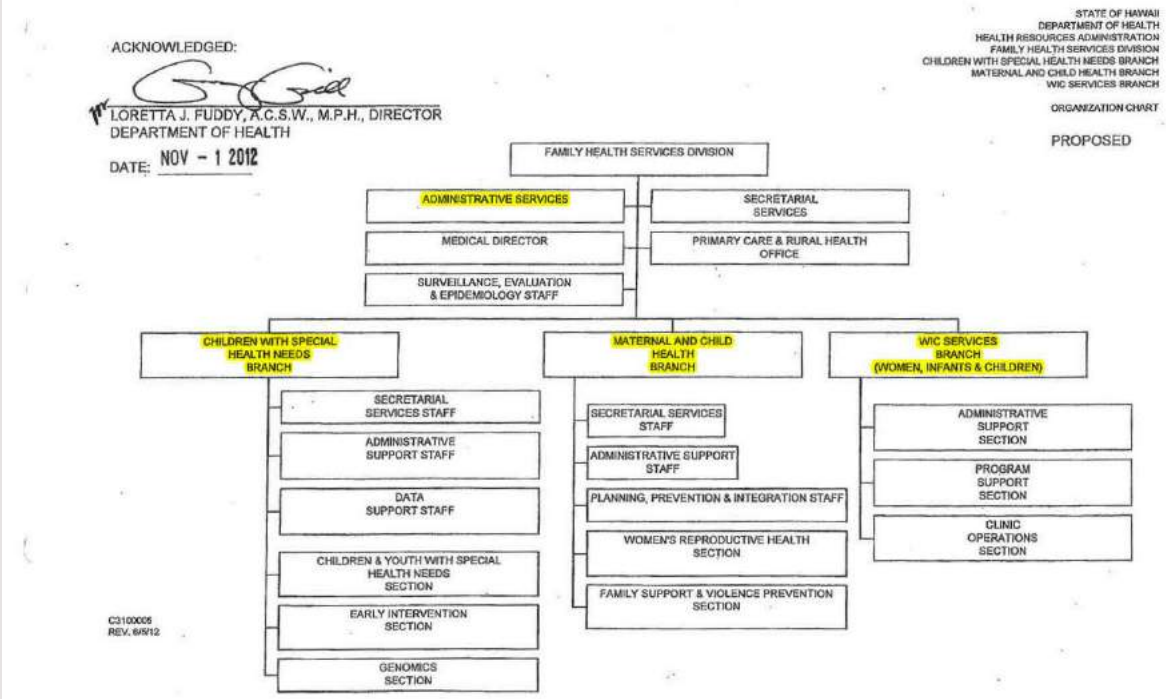

ACKNOWLEDGED:
LORETTA J. FUDDY, A.C.S.W., M.P.H., DIRECTOR
DEPARTMENT OF HEALTH
DATE: NOV - 1 2012
STATE OF HAWAII
DEPARTMENT OF HEALTH
HEALTH RESOURCES ADMINISTRATION
FAMILY HEALTH SERVICES DIVISION
CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH
MATERNAL AND CHILD HEALTH BRANCH
WIC SERVICES BRANCH
ORGANIZATION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

Figure 3

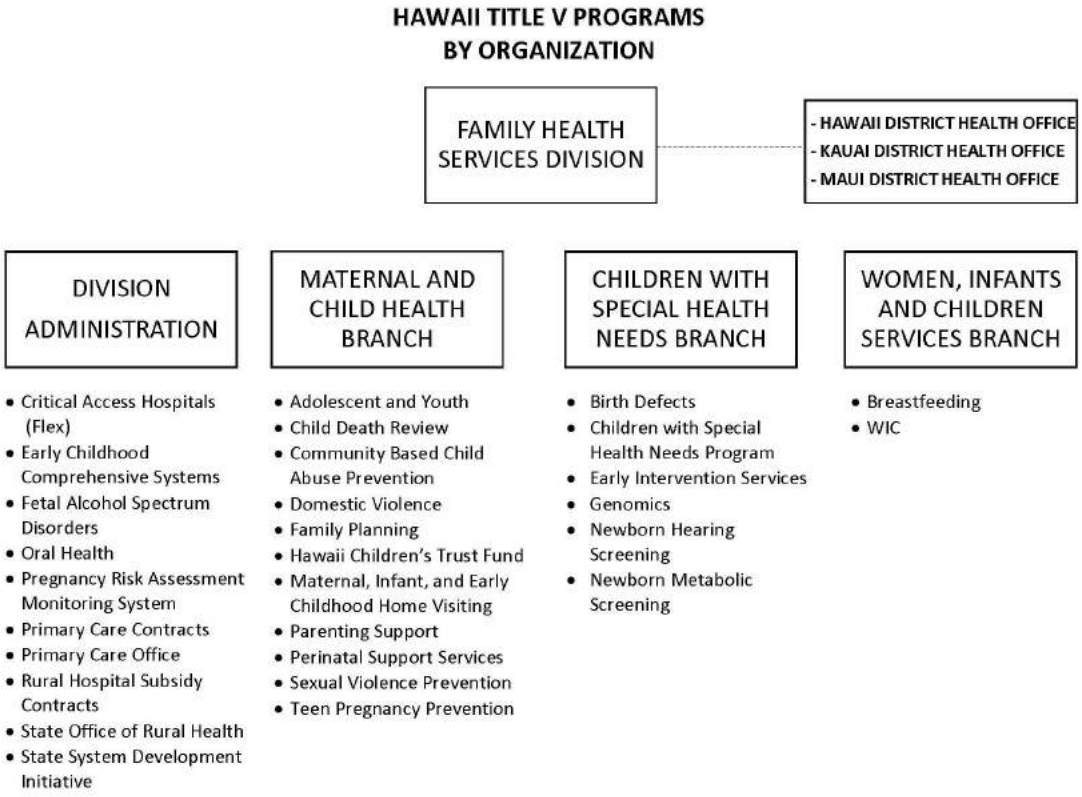



Figure 3.a.

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

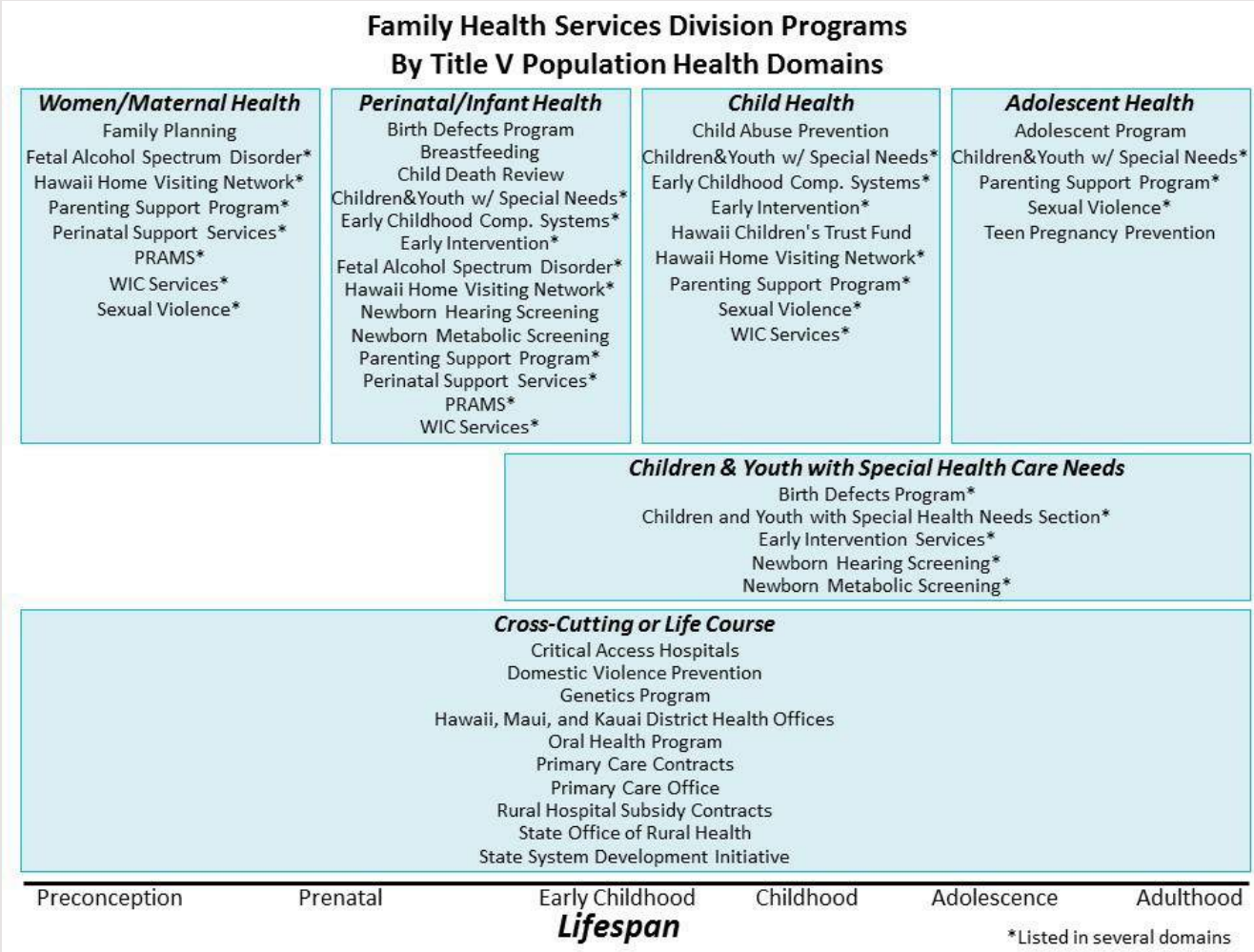
**STATE'S CAPACITY TO PROMOTE AND PROTECT THE HEALTH OF MOTHERS AND CHILDREN, INCLUDING CSHCN**

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

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

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

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




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

**ENSURING A STATEWIDE SYSTEM OF SERVICES**

State program collaboration with other agencies: Collaborations include:

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

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

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

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

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

State support for communities. Examples include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**MCH AND CSHCN WORKFORCE**

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

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

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

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

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

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

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

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

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

Needs and challenges:

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

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

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

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

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

**CULTURALLY COMPETENT APPROACHES**

Promoting culturally competent approaches in service delivery include:

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

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

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

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

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

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

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

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

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

**Other federal investments:**

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

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

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

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

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

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

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

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

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

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

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

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

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

**Other government agencies:** FHSD works with other departments including:

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

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

**Family/consumer partnership and leadership programs:**

- Family leaders/partners of diverse ethnicities participate on various councils, committees, and collaboratives, including:
    - Child Abuse Prevention Planning Council
    - Fetal Alcohol Spectrum Disorders Task Force
    - Hawaii Early Intervention Coordinating Council
    - Hawaii Maternal and Infant Health Collaborative
    - Newborn Hearing Screening Advisory Committee
    - Newborn Metabolic Screening Advisory Committee
    - State Systemic Improvement Plan for Part C
    - Western States Genetic Services Collaborative

- A family leader is part of the FHSD leadership team responsible for the Title V needs assessment process, identifying priority issues and performance measures, developing the Title V grant application, and planning for the Title V priorities.
- Family leaders participate as interview panel members for key CSHCN positions.

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

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

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

### II.C. State Selected Priorities

| No. | Priority Need |
|---|---|
| 1 | Promote reproductive life planning |
| 2 | Reduce the rate of infant mortality |
| 3 | Improve the percentage of children screened early and continuously age 0-5 years for developmental delay |
| 4 | Reduce the rate of child abuse and neglect with special attention on ages 0-5 years. |
| 5 | Improve the percentage of youth with special health care needs ages 14-21 years who receive services necessary to make transitions to adult health care. |
| 6 | Improve the oral health of children and pregnant women. |
| 7 | Improve the healthy development, health, safety, and well-being of adolescents |
| 8 | Improve access to services through telehealth |
| 9 | Improve family and consumer engagement in Title V Programs. |
| 10 | Improve partner engagement in Family Health Services Division (FHSD). |

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

| Domain | State Priority Need |
|---|---|
| **Women's/ Maternal Health** | Promote reproductive life planning |
| **Perinatal/ Infant Health** | Reduce the rate of infant mortality by improving breastfeeding rates and promoting safe sleep practices |
| **Child Health** | Improve the percentage of children age 0-5 years screened early and continuously for developmental delay |
| | Reduce the rate of child abuse and neglect with special attention on ages 0-5 years |
| **Adolescent Health** | Improve the healthy development, health, safety, and well-being of adolescents |
| **Children with Special Health Care Needs** | Improve the percentage of youth with special health care needs ages 14-21 years who receive services necessary to make transitions to adult health care |
| **Cross-Cutting or Life Course** | Improve the oral health of children and pregnant women |
| | Improve access to services through telehealth |
| | Improve family and consumer engagement in Title V programs (NEW in 2016) |
| | Improve meaningful partnerships with FHSD (NEW in 2016) |

**How Priority Needs were Determined**

FHSD conducted the 2015 needs assessment cognizant of strategically leveraging existing resources; building upon established collaborative initiatives; capitalizing on partnerships; and developing capacity by building on current programs, initiatives and strategies. Using this approach FHSD was able to reduce duplication of assessment

efforts on a small state population, and assure Title V priorities and plans were well-aligned with key partners in public health and the health care system.

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

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

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

**Change in State Priority Needs**

| Priority Needs 2011-2015 | Priority Needs 2016-2020 | Comment |
|---|---|---|
| **Reduce the rate of unintended pregnancy** | Promote reproductive life planning **CONTINUED** | Renamed/expanded broader approach, including also promoting preconception health care visits and healthy behaviors. |
| **Reduce the rate of alcohol use during pregnancy REPLACED** | | FHSD no longer has a Fetal Alcohol Spectrum Disorder (FASD) Coordinator position. Work on this area continues with the Hawaii Maternal and Infant Health Collaborative. |
| | Reduce the rate of infant mortality by improving breastfeeding rates and promoting safe sleep practices. **NEW in 2015** | Need identified through Title V needs assessment |
| **Reduce the rate of overweight and obesity in young children ages 0-5 REPLACED** | | FHSD does not have a lead role. DOH Chronic Disease Prevention and Health Promotion Division is the DOH lead for Physical Activity and Nutrition. |
| **Improve the percentage of children age 0-5 years screened early and continuously for developmental delay** | Improve the percentage of children age 0-5 years screened early and continuously for developmental delay **CONTINUED** | While rates are high, there is still a continued need for improvement |
| **Reduce the rate of child abuse and neglect with special attention on ages 0-5 years** | Reduce the rate of child abuse and neglect with special attention on ages 0-5 years **CONTINUED** | Data indicate need for improvement |

| | | |
|---|---|---|
| | Improve the healthy development, health, safety, and well-being of adolescents **NEW in 2015** | Need identified through Title V needs assessment |
| **Improve the percentage of youth with special health care needs age 14-21 years who receive services necessary to make transitions to adult health care** | Improve the percentage of youth with special health care needs ages 14-21 years who receive services necessary to make transitions to adult health care **CONTINUED** | Data indicate need for improvement |
| **Improve the oral health of children age 0-18 years** | Improve the oral health of children and pregnant women **CONTINUED** | Pregnant women were added to be more aligned with the National Performance Measure |
| | Improve access to services through telehealth **NEW in 2015** | Need identified through Title V needs assessment |
| | Improve family and consumer engagement in Title V programs **NEW in 2016** | Need identified through Title V needs assessment |
| | Improve meaningful partnerships with FHSD **NEW in 2016** | Need identified through Title V needs assessment |

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

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

| Domain | State Priority | Related National Performance Measure (NPM) | Rationale for Selection of NPM |
|---|---|---|---|
| **Women's/ Maternal Health** | Promote reproductive life planning | NPM 1 – Percent of women with a past year preventive medical visit | Preventive health visits help women to adopt or maintain healthy habits and behaviors, detect early and treat health conditions, plan for a healthy pregnancy, and consider reproductive life planning. |
| **Perinatal/ Infant Health** | Reduce the rate of infant mortality by improving breastfeeding rates and promoting safe sleep practices | NPM 4 – A) Percent of infants who are ever breastfed. B) Percent of infants breastfed exclusively through 6 months. | Breastfeeding has been shown to lower the risk of Sudden Infant Death Syndrome. Health advantages of breastfeeding include nutritional, immunological and psychological benefits to both mother and infant as well as economic benefits. |
| | | NPM 5 – Percent of infants placed to sleep on their backs. | Sleep-related deaths are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. |
| **Child Health** | Promote early childhood screening and development | NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool. | Screening is important for the early identification of developmental concerns and appropriate follow-up, including referrals to early intervention or special education services. |
| | Prevent child abuse and neglect | NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children age 0 through 9 and adolescents age 10 through 19. | Injuries are the leading cause of death among children. Non-fatal injuries due to child abuse and neglect may result in hospitalization. |
| **Adolescent** | Promote | NPM 10 – Percent of | Preventive health visits help |

| | | | |
|---|---|---|---|
| **Health** | adolescent well-being | adolescents, ages 12 through 17, with a preventive medical visit in the past year. | adolescents adopt or maintain healthy habits and behaviors, manage their health and health care, manage chronic conditions, and plan their transition to adult health care. |
| **Children with Special Health Care Needs** | Promote transition to adult health care | NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care. | Health and health care are major barriers to making successful transitions. Youth with special health care needs, compared to those without special health care needs, are less likely to complete high school, attend college, or be employed. |
| **Cross-Cutting or Life Course** | Improve oral health | NPM 13 – A) Percent of women who had a dental visit during pregnancy. B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year. | Access to oral health care is essential to reduce the risk of oral diseases. Without treatment, dental decay can cause pain and infection that can compromise a child's ability to eat, school attendance, and ability to concentrate and learn in the classroom. |

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

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

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

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

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

## II.F. Five Year State Action Plan

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

The plan narratives for application Year 2017 address the new National Performance Measures (NPM) by population domain as reflected in the 5 year plan. Hawaii is using the plan template provided in the Title V guidance. The Plan narratives:

- review the information found in the plan table including new strategy measures,
- discuss current activities,
- outline plans for application year 2017,
- discuss NPM and NOM data.

One state performance measures (SPM) was identified through the 5-year needs assessment. Two new SPM focusing on capacity building within the Hawaii Title V agency are included.

The FY 2015 annual report is presented by population domain. There were some minimal or no changes for most of the 2011-2015 NPM and SPM:

- Women/Maternal Health: The teen birth rate went down slightly in 2015.
- Perinatal/Infant Health: The proportion of mothers who smoked in the third trimester improved slightly while alcohol use in the third trimester worsened slightly.
- Child Health: the percent of 3rd graders receiving protective sealants improved slightly; while the percent of 2-5-year-olds in WIC at risk for overweight went down slightly. Those 2-5 year-old Native Hawaiian and Other Pacific Islander children also went down.
- Adolescent Health: No change in the measures where new data was available.
- CSHCN Health: No new data available.
- Cross Cutting/Life Course: No change in the measures where new data was available.

**Women/Maternal Health**

**State Action Plan Table**

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

Priority Need

Promote reproductive life planning

NPM

Percent of women with a past year preventive medical visit

## Objectives

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

## Strategies

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

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

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

## ESMs

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

## NOMs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### Measures

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 62 | 63 | 64 | 64 | 65 | 65 |

**Data Source: Behavioral Risk Factor Surveillance System (BRFSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 61.1 % | 2.0 % | 146,768 | 240,110 |
| 2013 | 62.3 % | 1.9 % | 150,121 | 241,032 |
| 2012 | 61.6 % | 1.9 % | 145,213 | 235,637 |
| 2011 | 55.0 % | 2.1 % | 128,425 | 233,413 |
| 2010 | 54.8 % | 2.2 % | 120,779 | 220,266 |
| 2009 | 56.7 % | 2.2 % | 126,764 | 223,508 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 30.0 | 30.0 | 29.0 | 29.0 | 28.0 |

### Women/Maternal Health - Plan for the Application Year

**Priority Need: Preventive Medical Visit**

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

- Executive Office of Early Learning Action Strategy Planning (specifically the component focused on "Healthy and Welcomed Births",
- 2013 National Governor's Association (NGA) Learning Network to improve Birth Outcomes,
- Establishment of the Hawaii Maternal and Infant Health Collaborative (HMIHC) to improve birth outcomes and

reduce infant mortality, and

- Hawaii participation in the national Infant Mortality Collaborative Improvement and Innovation Network (CoIIN).

The Title V agency 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. The Hawaii team participated in the 2013 Learning Network Conference on Improving Birth Outcomes held in a Washington, D.C. too assist states in developing, implementing and aligning their key policies and initiatives related to the improvement of birth outcomes. The Conference also allowed states to share lessons learned and to further their respective planning processes. This TA supported 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 (EOEL) Action Strategy initiative which included a workgroup on "Healthy and Welcomed Births."

The Hawaii Maternal and Infant Health Collaborative (HMIHC) was formed to sustain the planning and implementation work begun through NGA TA. The HMIHC completed a strategic plan and Logic Model, The First 1,000 Days, aimed at achieving the outcomes of 8% reduction in preterm births and 4% reduction in infant mortality by 2020. To date, over 80 participants across Hawaii have been involved in the HMIHC. The members include physicians and clinicians, public health planners and providers, insurance providers and health care administrators.

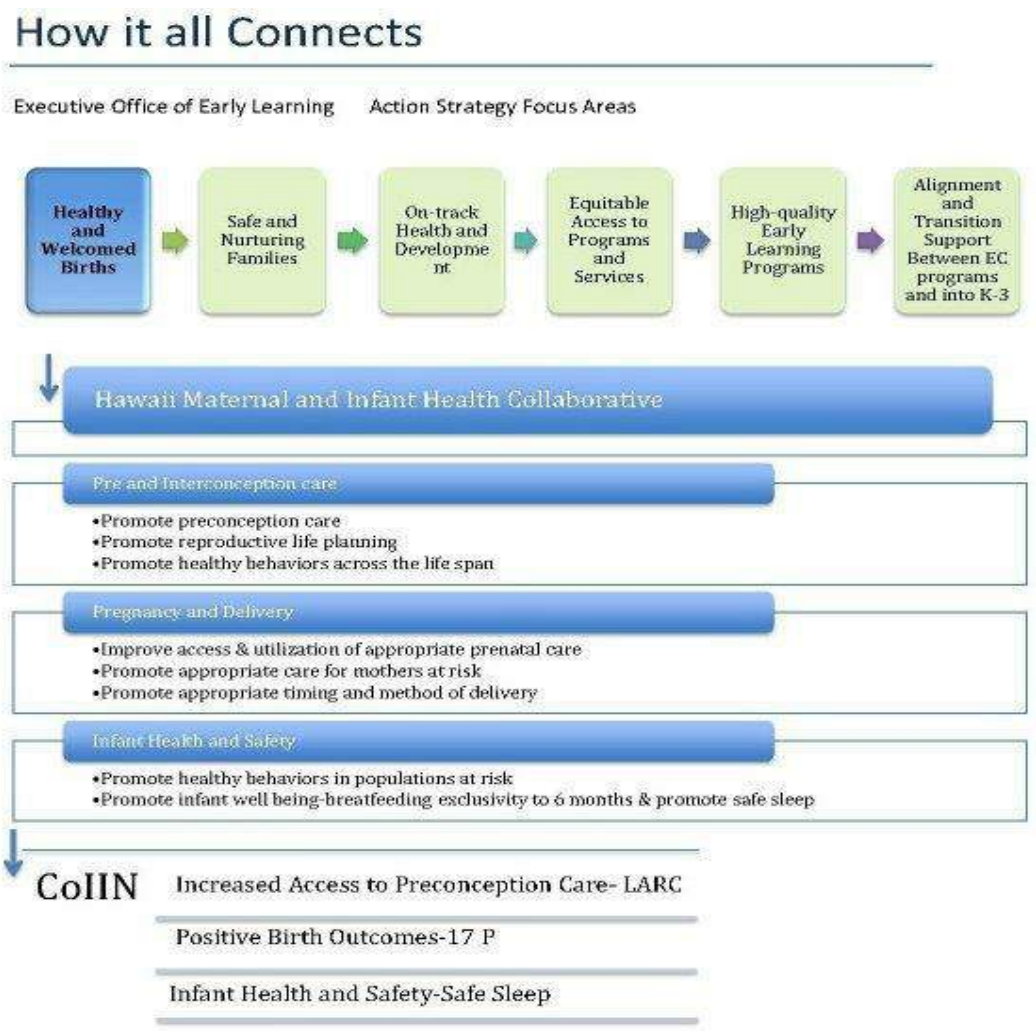
Women's preventive health is viewed as a critical factor to reducing infant mortality and improving birth outcomes. Thus, the HMIHC has a work group focused on preconception and interconception care and the health of reproductive aged women.

Subsequently, the State participated in the July 2015 Infant Mortality Collaborative Information and Innovative Network (CoIIN) Summit and utilized the strategic goals set by the HMIHC to select CoIIN projects for Hawaii. Hawaii has also drawn from the HMIHC to provide leadership and direction for CoIIN projects. Each CoIIN project has a Department of Health (DOH) and community partner as co-leaders. The State team also participated in the Boston CoIIN In Person Learning Session 2, July 27-28, 2015. From this session the team was introduced to the One Key Question® (OKQ) and has integrated this screening approach into the HMIHC workplan to improve preventive health for reproductive age women.

The HMIHC goals for women's preventive health (preconception and interconception care) are to reduce unintended pregnancy and improve birth spacing through reproductive life planning education and counseling. To achieve this priority long acting reversible contraception (LARC) was adopted as an evidence based strategy from the CoIIN project. Other strategies include incorporating pregnancy intention screenings in routine and preventive settings where reproductive age women are likely to be screened every 3 months to a year. Regardless of the reason for a women's visit, the use of OKQ provides multiple opportunities which can lead to provision of preconception care and contraceptive services.

Reducing unintended pregnancy was a Title V priority from the previous 5-year project period and still considered important by the HMIHC. Expanding the focus on women's preventive health overall is a new Title V priority for Hawaii. However, Family Health Services Division (FHSD), the Title V agency, recognizes the importance of women's health. FHSD's Maternal and Child Health Branch has a "Women's and Reproductive Health Section" that includes programs for Adolescent health, Perinatal health and the federal Title X Family Planning services grant. The grouping of these programs organizationally allows the Section to maximize its limited staff and funding by increasing collaboration among the existing programs and improving partnerships with community based organizations.

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




**National Performance Measure 12**: Percent of women ages 18 through 44 with preventive medical visit in the past year.

**Objective**

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

The state priority is based on the Title V block grant guidance National Performance Measures (NPM) for women's health. The HMIHC identified several objectives relating to women's preconception and interconception health which do not include the Title V NPM for women's health. Discussions were conducted with the Title V women's health program staff, the CoIIN project team, and HMIHC leadership group to determine the best alignment with the HMIHC plan, 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 services)
- Promote healthy behaviors (e.g. smoking cessation, decrease alcohol and substance use, maintain healthy weight, use of folic acid, chronic disease control)

**Strategy Development**

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

**Evidence Based/ Informed Strategy Measures**

The Evidence Based/ Informed Strategy Measure (ESM) selected for women's preventive medical visits is the percent of births with less than 18 months spacing out of total births. The measure is related to one of the HIMHC goals for women's preventive health (preconception and interconception care) to improve birth spacing through reproductive life planning education and counseling.

The measure uses vital statistics data from birth certificates with valid clinical estimates of gestational age of index birth and prior live birth. Objectives for the ESM were set to achieve a 5% improvement by 2021 and was based on 2014 data of 29.9% of births had pregnancy interval of < 18 months. Data will be update annually by the FHSD research statistician and reviewed by the epidemiologist. See Form 10C for the Detail Sheet.

**Plans for Application Year Federal Fiscal Year 2017 (10/1/16-9/30/17)**

The original Pre- and Interconception work plan includes the following activities:

- Write a white paper as to the benefits and safety of LARC
- Clarify policies for Medicaid and private insurance on LARC reimbursement immediately postpartum prior to discharge, and outpatient visits for women of reproductive age, if requested; and distribute LARC chart of coverage and coding for clinicians
- Assess need for provider training on changes to LARC coverage and codes, placement and removal of devices, and client counseling to increase provider competency
- Increase voluntary utilization of LARC in our adolescent population
- Encourage hospital in-patient pharmacy LARC stocking
- Assess if barriers have been reduced (e.g. availability of pharmacy stock for hospital in-patients)
- Design and conduct public and provider education on LARC
- Hold clinical and non-clinical OKQ implementation training
- Develop OKQ implementation plan
- Conduct contraceptive training for non-clinical staff implementing OKQ

A summary of activity implementation includes:

- In September 2014, HMIHC developed a white paper on Medicaid and Insurance Reimbursement for Immediate Post-Partum Long Acting Reversible Contraception. This supported the discussion and improvement for billing and reimbursement for LARC immediately post-partum and reduction of unintended pregnancy.
- HMIHC through its partnerships with Medicaid, Governor's Office on Health Care Transformation, and JABSOM completed an assessment of Medicaid insurance policies related to reimbursement for LARC placement immediately post-partum. This Reimbursement Guide for providers clarifies coverage for LARC by all Hawaii Medicaid plans. March of Dimes Hawaii Chapter funded the development and dissemination of the guide distributed at the Hawaii ACOG annual meeting in November 2015. Faculty from JABSOM presented at the meeting including the benefits and placement of LARC, clinical guidelines for adolescents and LARC, and review of the Hawaii LARC Reimbursement Guide.

- Two face-to-face meetings for up to 70 collaborative stakeholders including neighbor island representation. One meeting was held during January 2016 sponsored by the HMIHC with administrative support from a Maternal and Child Health contract with Healthy Mothers Healthy Babies Coalition of Hawaii. This included discussion of opportunities to expand efforts to improve preventive women's health care not limited to LARC and implementation of OKQ.

In addition to the work of the HMIHC there are also efforts occurring through the DOH family planning program to support the HMIHC plan activity. The DOH as the Title X Family Planning Services grantee provided 17,883 clients (27,336 visits) comprehensive statewide family planning services in FY2015 not limited to client-centered education and counseling, pregnancy testing and counseling, basic infertility services, preconception health, sexually transmitted disease (STD) testing, and other related preventive health services. According to CDC in April 2015[1], Hawaii ranked the 5th highest state in the nation in the percentage of female teen's aged 15-19 using LARC in 2005-2013 in Title X sites. It should be noted that the number of teens seen at Title X clinics is small and not representative of the State as a whole, (2,787 teens using LARC during 2005-2013). Over 80% of the Hawaii Title X clients leave with a moderately to highly effective methods, and clients are encouraged to return for their annual exams to ensure continued coordinated compliance with their method and to assess other health needs. In October 2015, a reproductive health conference was held and provided hands-on training for clinicians in intrauterine device placement. The Hawaii Title X performance measure to monitor annual STD testing of clients under 25 years of age should also increase the number of preventive medical visits for these women.

FHSD through its MCH Branch will continue to participate in the HMIHC, CoIIN, EOEL Action Strategies to implement the women's preventive health activities described above. This participation supports assessing progress to date, identifying opportunities for continued improvement in reducing infant mortality, promoting cross-state collaborations and identifying new approaches, improving use of data and forming plans to integrate stakeholders to move forward practice improvement. HMIHC continues to hold its monthly meetings including the preconception/interconception work groups meeting to address the priority of preventive medical visits.

A scale has been created to monitor/track progress made on the 5-Year plan strategies for HMIHC Pre-Interconception care workgroup. The Workgroup will complete the scale annually as part of routine evaluation.

| Element | 0 Not Met | 1 Partially met | 2 Mostly met | 3 Completely met |
|---|---|---|---|---|
| **Increasing Access to Reproductive Health Services** | | | | |
| 1. Expand access to LARC and other contraceptive information by designing and conducting public and provider education. | | | | |
| 2. Encourage hospital in-patient pharmacy LARC stocking. | | | | |
| 3. Clarify LARC private health plan reimbursement, develop LARC chart and distribute LARC chart of coverage and coding for clinicians. | | | | |
| 4. Hold clinical (family planning/primary care provider training, May 2016) and non-clinical (WIC and home visiting providers July 2016) OKQ implementation training. | | | | |
| 5. Develop OKQ implementation plan | | | | |
| 6. Conduct contraceptive training for WIC and home visitation staff implementing OKQ. | | | | |
| **Tracking/monitoring HMIHC Pre- Interconception work plan activities** | | | | |
| 1. Develop more detailed tracking and metrics for HMIHC pre/interconception work plan activities. | | | | |
| 2. Develop and annually update the HMIHC pre/inteconception work plan activities as required to meet overall goal. | | | | |

**Total Score (possible 0-21) _____**

**Factors Contributing to Success**

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

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

In addition, Title V utilized resources of key partners to provide leadership, staffing and funding to sustain these collaborative efforts over the past three years. These resources are crucial since the Maternal and Child Health Branch staffing and management has been hampered by significant turnover, loss of staffing due to funding cuts over the past 5 years.

An example of the collaborative use of resources include funding the hiring of a facilitator/coordinator for the HMIHC and CoIIN projects for the HMIHC work through the DOH Centers for Disease Control (CDC) Preventive Health and Health Services Block Grant (PHHSBG). Administered by the DOH Office of Planning, Policy and Program Development, the CDC grant funding sustains the momentum and work of the Collaborative. Additional PHHSBG funding has supported LARC activities including workforce training.

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

**Challenges, Barriers**

Some of the challenges to implementing activities include:

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

[1] Centers for Disease Control and Prevention. Vital Signs: Trends in Use of Long-Acting Reversible Contraception Among Teens Aged 15-19 Years Seeking Contraceptive Services – United States, 2005- 2013. a Morbidity and Mortality Weekly Report, April 7, 2015.

**Women/Maternal Health - Annual Report**

For the Women/Maternal Health 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 1: Unintended Pregnancy
- SPM 2: Alcohol During Pregnancy

***NPM 15: Percentage of women who smoke in the last 3 months of pregnancy.***

Smoking is the single largest known preventable risk factor for poor pregnancy outcomes. The 2015 data (latest available) indicates 4.2% of pregnant women reported smoking during the last trimester of pregnancy. The State objective of 4.5% was met; the Healthy People 2020 Objective of 1.4% was not met.

According to Hawaii PRAMS data from 2010-2012, of the women who smoked prior to pregnancy, 30.3% smoked during the last trimester of pregnancy and 65.4% reported smoking 2-9 months postpartum. 72.2% discussed effects of smoking with provider during PNC.
Title V administers the Perinatal Support Services (PSS) program with seven contracted providers on Oahu, Maui island, Molokai and Hawaii island (east Hawaii). 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.

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.

Smoking during pregnancy may include other substance use. Other substance use related activities by the Hawaii MCH nurse included radio public service announcements, with local women's voices and stories developed and aired island-wide on 3 stations, May 10 to 16, 2015. "Pregnant and using? Enough already" posters was also developed with local women and distributed island-wide during May 2015. The Hawaii MCH nurse was also the organizer and facilitator for the East Hawaii Substance Abuse in Pregnancy Community Action Team meetings in February, April, June and August 2015 leading to a pilot project (starting October 2015) "9 Months: Window of Hope" that targets 20 women who are pregnant and using substances with the goal of promoting sobriety during pregnancy.

The Hawaii Maternal and Infant Health Collaborative (HMIHC) workgroups is focused on pregnancy and delivery with the goal to decrease preterm births and ensure infants are born healthy. Having a system in place for screening, brief intervention and referral for universal prenatal substance use was a major focus of HMIHC work in 2015. The

DOH primarily through the Office of Planning and Policy Development provided leadership for this effort and key partners included the Hawaii Community Foundation and the Health Care Transformation State Innovation Team. Outcomes included prioritizing the prenatal population, securing key leadership support and grant funding to begin system implementation. Hilopa'a - Family to Family Information Center was the grant recipient. Hilopa'a works closely with FHSD and its branches on numerous projects including Title V planning.

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 "Test4baby" program. See NPM 18 for additional information.

A revised PRAMS survey will begin in 2016 and 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 2015 indicates 77.9% of pregnant women received first trimester PNC. The state objective of 86% 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 seven contracted providers including Oahu, Maui island, Molokai, and Hawaii island (east Hawaii). 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.

Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii provided system building support to improve statewide perinatal services. In July 2014, a request for proposals was issued to enhance the statewide system of perinatal and women's health care through systems building and advocacy, pregnancy resources, referrals and information; and, perinatal support service provider education and training. This contract with HMHB began July 1, 2015 with services to continue through June 30, 2017. The scope of work includes convening the Statewide Perinatal Provider Advocacy Network meetings to facilitate discussions on legislation, perinatal service issues, and to share strategies to assure early and ongoing PNC by improving outreach and case management; working with the Hawaii Maternal and Infant Health Collaborative (HMIHC) and the MCHB to develop and implement two face-to-face meetings to facilitate action supporting improved perinatal and women's health including access to PNC; and, maintaining a toll-free statewide phone line and website for women and their families in Hawaii to access pregnancy resources, referral. HMHB also manages "Text4baby" that includes information on PNC.

In May 2013, the DOH was selected to join the National Governor's Association (NGA) Learning Network to Improve Birth Outcomes to assist states to develop, implement and align key policies and initiatives to improve birth outcomes. Approximately 60 private and public stakeholders attended the NGA In-State Planning Session on July 17, 2013. Participants emphasized the need to have a life course approach; a collaborative to address improvement of birth outcomes including the clinical services; access to data for ongoing assessment; and assure continued support for collaboration and planning. As a result of the planning session the 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 infant mortality by 2018. There are now over 80 private and public stakeholders who have been engaged in the HMIHC. Participants include physicians and clinicians, public health planners and providers, insurance providers and health care administrators. Three workgroups have been formed:

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

In July 2014, the DOH along with public-private partners participated in the national Collaborative Improvement and Innovation Summit (CoIIN) to Reduce Infant Mortality in WA, DC, to share information on Hawaii activities and hear from national experts. In July 2015, the DOH along with public-private partners participated in the Infant Mortality CoIIN Learning Collaborative, Learning Session 2 in Boston, Massachusetts. This CoIIN participation helped support and enhance the HIMHC work. The compelling presentation on One Key Question ® (OKQ) was integrated into the HIMHC plan. The use of OKQ supports preconception care, reproductive life planning and access to prenatal care in the first trimester.

The HIMHC has 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.

One of the HMIHC workgroups formed is focused on pregnancy and delivery with the goal to decrease preterm births and ensure infants are born healthy. See NPM 15 and NPM 17 for more information on actions related to having a system in place for screening, brief intervention and referral for universal prenatal substance use, and to increase appropriate utilization of 17P (Alpha-hydroxyprogesterone caproate) in pregnant women with a history of preterm birth.

The Hawaii PRAMS survey continues to include questions on prenatal care and provides valuable data/information utilized routinely by HMIHC and perinatal stakeholders.

***SPM 1: The 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 (latest available data), although the data is provisional. The state objective was not met, nor was the Healthy People 2020 Objective of 46%.

In 2013, 71,210 women aged 13-44 in Hawaii were in need of publicly supported contraceptive services and supplies. 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, for both clients and providers, but challenges remain to acceptance and utilization. There remains a need to increase awareness and access to accurate information and to promote client-centered counseling approaches that includes discussing the most effective contraceptive methods first and providing these methods at reduced or at no cost to the clients.

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 35 clinic sites in 10 community health centers, 1 community 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 24,954 clinic visits by 16,678 clients in FFY 2015. Over two-thirds of clients received services through community health centers (CHC), over 80% had incomes less than 100% of the Federal Poverty Level, and 27% were uninsured. The proportion of FP clients who have a positive pregnancy test and stated they are avoiding pregnancy continues to decline to 32% in FFY15. Our data indicates 80% 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, and use of condoms in addition to a chosen contraceptive method are integral components of the FP services. Over 85% of female FP clients aged 20 and under use a highly effective to moderately effective contraceptive method.

The 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 and provide outreach education on how to access family planning services through distribution of educational materials, health fairs, and mass media. There were 21,345 adolescent and 13,851 male educational contacts made in FFY 2015. In addition, 21,760 direct contacts and 247,106 indirect contacts were served,

The Title X funded digital video disk (DVD) presentation on FP and CM (previously translated into Marshallese, Chuukese, Vietnamese and Mandarin languages) is being translated into Phonephian, Ilocano and Tagalog languages by Kalihi Palama Health Center. The DVD is given to clients to take home and have follow-up discussions with partners and significant others to assist with the decision process on contraceptive use.

A preconception and interconception workgroup as part of the Hawaii Maternal Infant Health Collaborative (HMIHC) meets monthly with the overall goal to reduce unintended pregnancies and improve birth spacing. Work was started in 2015 on the objective of increasing access to Long Acting Reversible Contraception (LARC). In 2015, the HMIHC clarified MedQUEST (Medicaid) coverage, developed and distributed a chart of coverage and coding for clinicians, wrote and distributed a white paper as to the benefits and safety of LARC, planned for this information to be presented in November at both the annual ACOG Hawaii Section conference and a LARC practicum to be included in a Reproductive Health Family Planning Provider training. In July 2015, the DOH along with public private partners at a CoIIN Learning Session 2 was introduced to the One Key Question ® (OKQ) and the DOH family planning program will take an active role.

***SPM 2: 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 2015 indicator is 7.9% (the latest available data from 2012); 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 seven contracted providers on Oahu, Maui island, Molokai and Hawaii island (east Hawaii) that 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 provide brief interventions and referrals for treatment.

The WIC program at the initial client visit uses a health questionnaire to screen for alcohol use during pregnancy and refers when appropriate.

Title V continued through the FHSD facilitated some meetings for the Fetal Alcohol Spectrum Disorder (ASD) Task Force (TF) comprised of private/public partners. The TF decided to defer its work to that which was occurring within the HMIHC on Screening Brief Intervention and Referral to Treatment (SBIRT).

On the State of Hawaii, Department of Health website there is a link to Family Health and a link to information on Fetal Alcohol Spectrum Disorder (FASD) (http://health.hawaii.gov/fasd). Information includes what is FASD, effects of FASD, and facts including Hawaii information and links to other information including Hawaii PRAMS data, CDC and a SAMSHA factsheet.

On November 13, 2014 the Hawaii District Health Office (DHO) MCH nurse coordinated a screening of the film, “Moment to Moment: Teens Growing up with FASD” with 32 attendees including the DOE and other agencies. Dr. Ira Chasnoff was a speaker.

In March 2015, Maui DHO participated in a prenatal alcohol exposed infant mock trial at Maui High School, 10th Grade with some students and DOE staff. Students were educated on the identification, signs and symptoms, societal costs, and interventions for prenatal alcohol exposed infants and children.

On September 3, 2015 the Maui DHO was involved with the County Maui Mayor’s Proclamation on International FASD Awareness Day with over a dozen public-private organizations. This included a FASD poster display on

alcohol and other substance use in pregnancy and community resources for children exposed to alcohol and other substances.

On July 16, 2015 the Maui DHO introduced the Maui SBIRT Hawaii Community Foundation Grant Project and 4 P's Plus Screening Tool to 15 Maui OB/GYN's.

"Why Take a Chance, No Amount of Alcohol is Safe for your Baby" bus placards on the warning signs of alcohol use during pregnancy were installed on the Oahu bus fleet in October will stay up through December 2015, along with other county bus systems including Maui.

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.

**Perinatal/Infant Health**

**State Action Plan Table**

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

### Priority Need

Reduce the rate of infant mortality

### NPM

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

### Objectives

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

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

### Strategies

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

Use community-based organizations to promote and support breastfeeding.

### ESMs

ESM 4.1 - Percent of WIC infants ever breastfed

### NOMs

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

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

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

### Priority Need

Reduce the rate of infant mortality

### NPM

Percent of infants placed to sleep on their backs

### Objectives

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

### Strategies

Review 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.

### ESMs

ESM 5.1 - Percent of birthing hospitals with current AAP safe sleep protocols

### NOMs

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

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

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

## Measures

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 90.0 | 91.0 | 92.0 | 93.0 | 94.0 | 94.0 |

**Data Source: National Immunization Survey (NIS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2012 | 85.0 % | 3.2 % | 13,926 | 16,385 |
| 2011 | 89.5 % | 2.5 % | | |
| 2010 | 87.8 % | 2.3 % | | |
| 2009 | 84.9 % | 3.6 % | | |
| 2008 | 85.9 % | 2.1 % | | |
| 2007 | 87.0 % | 2.3 % | | |

**Legends:**

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 27.0 | 27.0 | 27.0 | 27.0 | 28.0 | 28.0 |

**Data Source: National Immunization Survey (NIS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2012 | 27.1 % | 3.5 % | 4,389 | 16,213 |
| 2011 | 26.4 % | 3.2 % | | |
| 2010 | 22.4 % | 2.8 % | | |
| 2009 | 22.9 % | 2.8 % | | |
| 2008 | 22.6 % | 2.5 % | | |
| 2007 | 18.0 % | 2.3 % | | |

**Legends:**

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**ESM 4.1 - Percent of WIC infants ever breastfed**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 95.0 | 95.0 | 96.0 | 97.0 | 98.0 |

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 79 | 79 | 80 | 81 | 82 | 82 |

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2012 | 82.0 % | 1.3 % | 14,851 | 18,103 |
| 2011 | 78.1 % | 1.4 % | 14,329 | 18,339 |
| 2010 | 74.5 % | 1.4 % | 13,587 | 18,235 |
| 2009 | 76.9 % | 1.3 % | 13,851 | 18,001 |
| 2008 | 71.6 % | 1.1 % | 13,095 | 18,298 |
| 2007 | 71.7 % | 1.1 % | 12,825 | 17,878 |

**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

**ESM 5.1 - Percent of birthing hospitals with current AAP safe sleep protocols**

**Annual Objectives**

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Annual Objective | 60.0 | 70.0 | 80.0 | 90.0 | 100.0 |

**Perinatal/Infant Health - Plan for the Application Year**

**Priority Need: Breastfeeding**

The 5-year needs assessment affirmed the importance of breastfeeding as a priority issue. Breastfeeding is the normative standard for infant feeding and nutrition that can help to improve infant and maternal health outcomes. Two important state maternal and child health improvement efforts - the Hawaii Maternal and Infant Health Collaborative and the Executive Office of Early Learning's Action Strategy – have identified promotion of breastfeeding as an important practice to improve birth outcomes and reduce infant mortality.

The Title V agency, Family Health Services Division, includes the WIC program which is the largest public breastfeeding promotion program in the nation, providing mothers with education and support. In addition, WIC also provides breastfeeding training to service providers working with pregnant women and new mothers.

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

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

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.

**National Performance Measures:**

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

**Objectives:**

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

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

**5-Year Strategies:**

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

**Strategy Development**

The strategies were extracted from the Actions for Communities section of the 2011 Surgeon General's Call to Action to Support Breastfeeding and are generally accepted by Hawaii breastfeeding stakeholders including the Hawaii Breastfeeding Council, the Executive Office of Early Learning Action Strategy workgroup, HMIHC, the perinatal action network, Healthy Mothers, Healthy Babies and the March of Dimes.

**Evidence/Expert Informed Strategy Measures (ESM)**

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

WIC is the largest public breastfeeding promotion program in the state and nation, providing mothers with education and support as a core service. Moreover, promoting and/or facilitating community activities that reinforce breastfeeding may allow for more women across the state to have access to the support they need to initiate breastfeeding and continue doing so exclusively for at least 6 months.

**Plans for Application Year Federal Fiscal Year 2017 (10/01/16-09/30/17):**

- Train home visitors and WIC staff on helping mothers overcome common breastfeeding challenges.
- Refer all pregnant moms served by Division programs 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.

The FHSD WIC program is the lead for this priority to assure implementation of the project activities outlined. An update on progress will be provided in next year's Title V report and needed adjustments made to the 5-Year Plan.

**Factors Contributing to Success**

Title V programs serving high-risk pregnant women offer an opportunity to promote breastfeeding through

education and support services including WIC, the Maternal and Child Health Branch Perinatal Support Services program, and the Hawaii Home Visiting Network, supported by the Hawaii Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant. The Title V Early Childhood Comprehensive Systems (ECCS) coordinator also assisted to assure breastfeeding in integrated into state systems planning and services where appropriate. ECCS helped to coordinate and fund breastfeeding community trainings by WIC staff for the HHVN members statewide.

WIC includes breastfeeding promotion and support as a core service and has a dedicated Breastfeeding Coordinator. All WIC agencies have a designated breastfeeding coordinator and one breastfeeding coordinator at the state agency. WIC's Breastfeeding Peer Counselor Project, Hiilaupoli, conducts monthly group sessions for pregnant and breastfeeding WIC moms to address breastfeeding concerns. Information on WIC activities can be found in the outgoing NPM 11 narrative on breastfeeding in the Annual Report for this Perinatal/Infant domain.

Hawaii has an active state breastfeeding coalition, Breastfeeding Hawaii, comprised of diverse public-private partners. The state WIC breastfeeding coordinator is a board member of the State Breastfeeding Coalition. The organization helps sponsor trainings like that held in April 2016 Secrets of Baby Behavior. The 3-day Train the Trainer Workshop targeted representatives of hospital birthing facilities, other agencies and community partners including WIC, Home Visiting Network and the Healthy Hawaii Intitiative. The goals of the conference, presented by Jane Heinig & Carol Melcher, were to (1) increase the participants' knowledge of normal infant behavior and its impact on infant-feeding practices, and (2) develop and expand the participants' skills to teach Baby Behavior messages and counseling techniques to colleagues and staff. There were 26 participants, including Home Visitors and WIC staff, at the training. The Workshop was also funded and organized in collaboration with the State Department of Health Chronic Disease Prevention and Health Promotion Division and an Association of State and Territorial Health Officials grant.

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 in the community has been difficult due to the lack of a Statewide Breastfeeding Coordinator to serve all families, including those not serviced by WIC.

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

**Priority Need: 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. Two important state maternal and child health improvement efforts - the Hawaii Maternal and Infant Health Collaborative (HMIHC) and the Early Learning' Action Strategy – have identified promotion of safe sleep practices as an important priority to improve birth outcomes and reduce infant mortality. HMIHC 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. HMIHC 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.

Safe Sleep has been a part of the Title V Maternal and Child Health Branch program efforts since 2002 providing support and leadership for Safe Sleep Hawaii, a statewide committee that promotes life-saving safe sleep

techniques, policies and education for parents, teachers, health professionals, and other caregivers. The Committee members include the Departments of Health, Education and Human Services, hospital, military, child care agencies and the community. The Committee promotes each October as Safe Sleep Awareness Month and has secured legislative and gubernatorial proclamations and press releases to raise awareness of the issue.

The Safe Sleep Hawaii members have been working to support the establishment of safe sleep policies in all Hawaii's birthing hospitals. In 2013, Safe Sleep Hawaii worked to introduce and successfully pass legislation that required safe sleep practices to be addressed in licensed 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.

In 2015, Safe Sleep Hawaii and new safe sleep partners from the HMIHC joined together to participate in the national Infant Mortality Collaborative Improvement and Innovation Network (COIIN) as the Hawaii Safe Sleep Team. Through CoIIN, Safe Sleep Hawaii partners have been broadened including more hospitals, early child care partners, home visitors, parenting educators, nurses, physicians, parent advocates, and public and private agencies. Also critical has been the CoIIN technical assistance for the Safe Sleep priority from the National Institute for Children's Health Quality.

To help inform planning efforts, the Hawaii Safe Sleep Team worked to reinstitute the state's Child Death Review (CDR) to provide surveillance data which was temporarily suspended after budget cuts. In 2016, Senate Bill 2317 was passed to restore funding to the Department of Health to conduct child death reviews as well as implement a program to perform maternal death reviews which should also help inform the Title V maternal health priority. The programs will be administered by Title V's Maternal and Child Health Branch and will submit annual reports to the Legislature. In June a statewide CDR training was held for stakeholders, staff and members of the CDR councils.

**Priority:** Reduce the rate of infant mortality by promoting 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.

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

**Objectives:**

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

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

**5-Year Strategies:**

- Review 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 directly from the Safe Sleep Team's national CoIIN Initiative's Planning Worksheet. The strategies have been integrated into Safe Sleep Hawaii, HMIHC plans, and State Early Learning Action Strategies. The strategies will be shared more broadly with additional stakeholders over the next year.

**Evidence Based/Informed Strategy Measure**

The Evidence Based/Informed Strategy Measure (ESM) selected for safe sleep is focusing on the strategy addressing birthing hospital policies and training needs. The actual measure is "Percent of birthing hospitals with current American Academy of Pediatrics safe sleep protocols." In 2015, 5 of Hawaii's 12 birthing hospital met the measures (41.7% baseline). Safe Sleep Hawaii will collect and report the data for this measure. The objectives for the ESM were set by the Safe Sleep Team and reflect 100% completion rate by 2020. See Form 10C for the Detail sheet.

**Plans for Application Year Federal Fiscal Year 2017 (10/1/16-9/30/17):**

- Develop a survey for childcare providers to determine their preferred method of receiving training.
- 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 professionals working with new parents.
- Work with perinatal nurse managers to assess hospital protocols statewide.

FHSD will continue to work on the 5-Year plan strategies and activities described. An update on progress will be provided in next year's Title V report. Any needed changes to the 5-Year Plan or ESM will be made.

**Factors Contributing to Success**

One of the significant factors for success has been the Safe Sleep Hawaii Committee which was formed in 2002 by Dana Fong, a grandfather who became a safe sleep champion after experiencing a personal loss which may have been prevented if safe sleep information had been available.

Like the maternal health priority, Safe Sleep has also benefited tremendously from key state and national resources directed toward reducing infant mortality and improving birth outcomes. These resources include:

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

See NPM 1 for more information on these efforts.

**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 has focused on how to provide safe sleep education to parents in a way that engages the parents in making informed decisions on how they can create as safe of an environment as possible within the context of their living situation and values.

**Perinatal/Infant Health - Annual Report**

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

- NPM 1: Perinatal/Infant Newborn Screening
- NPM 11: Perinatal/Infant Breastfeeding
- NPM 12: Perinatal/Infant Hearing Screening
- NPM 17: Infant High Risk Deliveries

***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.***

In fiscal year (FY) 2015, 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), Department of Health (DOH). NBMSP has statewide responsibilities for assuring that all infants born in the state are tested for 33 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. The NBMSP began the process to increase fees from $55 to $99 to cover the cost of Severe Combined Immunodeficiency Disease (SCID) screening and the increase in general administrative costs. This requires a revision of the Hawaii Administrative Rules. The fee has not been increased since 2006.

A Critical Congenital Heart Disease (CCHD) bill, requiring hospitals to screen each newborn for CCHD with the use of pulse oximetry and to report the data and information to DOH, passed the legislature and was signed into law (Act 212, 2015). From July 1, 2015 hospitals are required to complete a spreadsheet with the demographics and results of infants born and forward it to NBMSP monthly.

SCID was added to Hawaii's newborn screening panel by the assent of the NBMSP Advisory Committee and screening began on March 1, 2015. Prior to beginning, the Genomics Section received a grant to assist with implementation. A partnership was formed with Kapiolani Medical Center for Women and Children, Mattel Children's Hospital at University of California Los Angeles (UCLA), and Genomics Section of the DOH. A protocol was developed for follow up, consultation, and technical assistance for a positive result. Available resources were identified on Oahu, the neighbor islands, and the mainland if a newborn required treatment not available in Hawaii. The UCLA partners visited Hawaii in August 2015 and participated in a half day continuing education conference on SCID for pediatric providers and meetings with project partners and Kapiolani Medical Center staff.

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 245 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 coordinators of the Newborn Hearing Program and the NBMSP provided

presentations at 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 breastfed their infants at 6 months of age.*

There is no new data for this measure at the time of the report. The 2014 data indicates that 61.5% of Hawaii mothers were breastfeeding their infants at 6 months, a decrease from the previous year 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 surpassed the 2014 national rate of 49.4%.

Title V administers Perinatal Support Services (PSS) 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.

Title V administers the Hawaii Home Visiting Network (HHVN) which provides breastfeeding information and support to participants. In partnership with WIC and the Hawaii District Health Office, members of the HHVN and others working with breastfeeding mothers received training to support capacity building in community based programs. The training on August 19, 2015 was conducted by WIC's Breastfeeding Peer Counselor (BFPC) Project Coordinator.

WIC's BFPC Project, Hiilaupoli, conducts "Talk Story" monthly group sessions for pregnant and breastfeeding WIC moms to address breastfeeding concerns. The most popular session, "Breastfeeding and Work, Let's Make It Work!" includes discussion on how to obtain/assemble/use a pump, hand expression, breastmilk storage, and the paced feeding method using breastmilk in a bottle. Mothers are empowered with tools, information and encouragement to start an early conversation with employers so employers are then better prepared and more accepting of the mothers' breastfeeding plan. Mothers learn about laws that support breastfeeding in the workplace and how lactation spaces can be modified with existing floor plans. Informing employers early on assist mothers in making a smooth transition back to work/school.

The WIC Breastfeeding Coordinator (BFC) participates as a board member to Breastfeeding Hawaii, a state coalition, and attends monthly meetings. WIC's BFPC board member activities help recommend and implement breastfeeding promotion efforts. 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.

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

The 2015 provisional data showed that 99.1% of newborns were screened for hearing before hospital discharge similar to the 2014 rate. The objective of 99% was met. The 2015 rate may 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 the Department of Health (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 hospital 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 Children with Special Health Needs Branch (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 2015. 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 20 members. The committee met four times in 2015. 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 CSHNB/Early Intervention Section Hearing Specialist and the Hands & Voices (H&V)-Hawaii Chapter and offered workshops and other activities for families with deaf/hard of hearing (D/HH) children. The “Hawaii State Resource Guide for Families of Children with Hearing Loss” was published in 2015 and is distributed to families with D/HH children who are enrolled in Early Intervention.

A work group was established to revise the Providers Guide for primary care physicians.

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. The Talking Point was finalized and distributed to midwives.

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 infants delivered at facilities for high-risk deliveries and neonates.*

The latest available data for this performance measure is the provisional data for 2014 indicating 90.5% of VLBW infants were delivered at facilities for high-risk deliveries and neonates. The objective was nearly 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 seven contracted providers on Oahu, Maui island, Molokai and Hawaii island (east Hawaii) 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 Healthy Babies Coalition of Hawaii (HMHB) to enhance the statewide perinatal system of care with a new contract beginning July 2015 on systems building and advocacy, pregnancy resource information, and perinatal provider training.

During the 2015 legislative session HB782 HD1 SD2 CD1 was passed requiring the Department of Health to establish a public education program to inform and educate women about cytomegalovirus. Efforts began within the Maternal and Child Health Branch (MCHB) to research consumer-friendly public education information for dissemination. The Centers for Disease Control and Prevention information, "What Women Should Know about Cytomegalovirus (CMV)" was selected. Over 28,000 brochures were printed and are now being distributed statewide through WIC, District Health Offices, home visiting providers, PSS and family planning providers. The Hawaii State Department of Health website also includes a link to the CDC brochure on Cytomegalovirus (CMV) and Pregnancy. www.cdc.gov/cmv/

The MCHB also coordinated with medical providers who developed CMV presentations for perinatal stakeholders and providers and family planning providers. The first presentation was held by statewide video-conference for the Perinatal Advocacy Network on CMV in Pregnancy Background and Clinical Recommendation Guidelines. Two CMV presentations were also planned for November 2nd (PSS provider meeting) and November 3rd (VCC family planning providers). The CSHNB is also involved in efforts to address CMV with the populations it serves.

See NPM18 for background information on the development of the Hawaii Maternal Infant Health Collaborative (HMIHC). A planning document was developed, "The First 1,000 Days", which aimed at achieving an 8% reduction in preterm births and 4% reduction in infant mortality by 2018. There are over 80 private and public stakeholders who have been engaged in the HMIHC. Participants include physicians and clinicians, public health planners and providers, insurance providers and health care administrators. One of the HMIHC workgroups formed is focused on pregnancy and delivery with the goal to decrease preterm births and ensure infants are born healthy. Having a system in place for screening, brief intervention and referral for universal prenatal substance use was a major focus of the HMIHC work in 2015. See NPM15 for additional information. Another objective of this work group was to increase appropriate utilization of 17P (Alpha-hydroxyprogesterone caproate) in pregnant women with a history of preterm birth. The team conducted a provider survey to help better understand the barriers to utilization and in 2016 plans to address those barriers through targeted patient education and outreach (NICU families, home visiting families) and to increase access, with clarification on insurance coverage.

Current information and link on the Zika virus is on the home page of the Hawaii State Department of Health (http://health.hawaii.gov) with a link to the Disease Outbreak Control Division (http://health.hawaii.gov/docd). The website includes information about Zika, Transmission, Signs and Symptoms, Treatment, for Pregnant Women including travel, Risk in Hawaii, Prevention, Resources, and Information for Clinicians. For questions about the Zika virus, the Hawaii 211 number is also provided. The DOH Disease Investigation Branch contact information is given to report a possible case and DOH Vector Control contact information is provided for concerns about mosquitos.

On the Hawaii State Department of Health website under Family Health/Children with Special Health Needs Branch there is further information regarding "Birth defects possibly linked to Zika virus (http://health.hawaii.gov/docd/dib/disease/zika_virus/) as well as information on Zika and Pregnancy and the MCH Branch Perinatal Support Services Programs (http://health.hawaii.gov/mchb).

The MCHB through its family planning and perinatal programs are also having presentations for stakeholders and providers on the Zika virus related to pregnant women and those of reproductive age using statewide video-conferencing and face-to-face meetings.

**Child Health**

**State Action Plan Table**

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

### Priority Need

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

### NPM

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

### Objectives

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

## Strategies

Systems Development - Hawaii partners will develop guidelines and a tool kit for early childhood providers and health professionals on the developmental screening, referral, and services system for children birth-5 years old, and provide trainings on these resources. o Develop guidelines and guidance sheet for screening, referral, and services. o Work with partners to develop infrastructure for ongoing training, technical assistance, and support for providers conducting developmental screening activities.

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

Data Integration – Within Family Health Services Division (FHSD), an internal data sharing system will be developed to monitor # of children screened from MCHB Home Visiting Programs, CSHNB Hi‘ilei Program, and # of referrals to Early Intervention Section (EIS), and # of children receiving services from EIS. o Develop data system for internal tracking and monitoring of screening, referral, and services data. o Develop process for on-going communication to review data findings and make adjustments for better outcomes for children and families.

Policy and Public Health Coordination - Hawaii will have developed within Family Health Services Division (FHSD) an infrastructure for developmental screening, referral, and services for children ages birth – five years in DOH programs. o Use Policy and Public Health Coordination Elements as a scale to measure the degree to which developmental screening, referral, and services for children ages birth-five years is developed.

## ESMs

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

## NOMs

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

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

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

### Priority Need

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

### NPM

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

### Objectives

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

### Strategies

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

Improve evaluation capacity of Title V Family Support and Violence Prevention Section programs to assure improved outcomes.

Improve communication, coordination, and collaboration and integration between programs addressing child wellness and family strengthening.

### ESMs

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

### NOMs

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

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

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

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

### Measures

#### 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 | 2021 |
| Annual Objective | 39 | 40 | 40 | 41 | 41 | 41 |

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 38.9 % | 3.1 % | 31,440 | 80,906 |
| 2007 | 27.3 % | 3.0 % | 21,477 | 78,824 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | Yes | Yes | Yes | Yes | Yes |

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 149 | 148 | 147 | 145 | 142 | 142 |

**Data Source: State Inpatient Databases (SID) - CHILD**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2013 | 150.1 | 9.2 % | 265 | 176,558 |
| 2012 | 143.3 | 8.9 % | 258 | 180,003 |
| 2011 | 165.4 | 9.6 % | 299 | 180,771 |
| 2010 | 148.9 | 9.4 % | 250 | 167,883 |
| 2009 | 176.1 | 10.4 % | 289 | 164,111 |
| 2008 | 141.7 | 9.1 % | 240 | 169,436 |

**Legends:**

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

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

**Annual Objectives**

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**Child Health - Plan for the Application Year**

**Priority Need: Developmental Screening**

Hawaii continues to focus on developmental screening as a priority issue based on results of the 5-year needs assessment. At both the state and federal levels, developmental screening has surfaced as a lever to help improve the health and well-being of children and families. Work continues on the findings of the public-private partnership led by the 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) Early Childhood Comprehensive Systems (ECCS) grant focusing on developmental screening activities of young children birth through age 3 is ending in July 2016. Hawaii received the next cycle of ECCS funding for 2016-2021 focusing on the island of Maui and developmental screening of three year olds using the 36 month window. This grant works in partnership with the Maternal Infant and 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. Hawaii will continue to receive funding for the MIECHV grant which promotes home visitors working with families on developmental

screening using the ASQ-3 and ASQ-SE tools.

Also at the federal level, the Affordable Care Act (ACA) has included developmental screening of infants and toddlers up to age 3 and surveillance after the age of three as a preventative service that is covered.

Hawaii's Title V Developmental Screening Workgroup will continue to work on these efforts in addition to focusing on internal coordination and integration amongst FHSD and DOH programs. Specific to Title V is the internal data integration where data to monitor the number of children screened from MCHB Home Visiting Programs, CSHNB Hi'ilei Program, and the number of referrals to CSHNB Early Intervention Section (EIS is Hawaii's Part C of Individuals with Disabilities Education Act agency), and the number of children receiving services from EIS. Data will be used for quality improvement purposes to see where changes in policies or procedures may lead to better outcomes for children and families.

The Title V Developmental Screening Workgroup Leader will continue to be involved in statewide and community-based efforts to improve the infrastructure for developmental screening and services focusing on the areas of: systems development, family engagement and public awareness, data integration, and policy and public health coordination. Many members of the Workgroup are also participants of the other state efforts so as not to over-burden the same people with more meetings, the Workgroup will meet as needed with monthly updates to keep the Workgroup abreast of new information and happenings.

**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 Measure 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.

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

**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 5-year plan objectives were developed using the baseline 2011_2012 data from the National Survey of Children's Health. Annual objectives were developed projecting a 5% improvement over the next five years.

**5-Year Plan Strategies:**

- Systems Development - Hawaii partners will develop guidelines and a tool kit for early childhood providers and health professionals on the developmental screening, referral, and services system for children birth-5 years old, and provide trainings on these resources.
    - Develop guidelines and guidance sheet for screening, referral, and services.
    - Work with partners to develop infrastructure for ongoing training, technical assistance, and support for providers conducting developmental screening activities.

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

- Data Integration – Within Family Health Services Division (FHSD), an internal data sharing system will be

developed to monitor # of children screened from MCHB Home Visiting Programs, CSHNB Hi'ilei Program, and # of referrals to Early Intervention Section (EIS), and # of children receiving services from EIS.
    - Develop data system for internal tracking and monitoring of screening, referral, and services data.
    - Develop process for on-going communication to review data findings and make adjustments for better outcomes for children and families.

- Policy and Public Health Coordination - Hawaii will have developed within Family Health Services Division (FHSD) an infrastructure for developmental screening, referral, and services for children ages birth – five years in DOH programs.
    - Use Policy and Public Health Coordination Elements as a scale to measure the degree to which developmental screening, referral, and services for children ages birth-five years is developed.

**Strategy Development**

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

**Evidence Based/Informed Strategy Measure**

The Evidence Based/Informed Strategy Measure (ESM) selected for developmental screening is focusing on the creation of a data sharing system within FHSD to collect the number of screenings, referrals, and services provided to children (ages birth-5) in the MIECHV Home Visiting Programs, the CSHNB Hi'ilei Program, and the Early Intervention Section which is the IDEA Part C agency. Once the data sharing system is developed, then Hawaii can actually see the "real" number of children being screened and tracked through referral into services. For Quality Improvement (QI), this data sharing will help pinpoint where increases in screenings, referrals, and follow up are needed. It may also show a need to reduce duplication or monitor where screenings are occurring but referrals are not.

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

Once the system is in place, the ESM will be adjusted to address the needs as identified by the data.

**Plans for Application Year Federal Fiscal Year 2017 (10/1/16-9/30/17):**

Hawaii was recently awarded the Early Childhood Comprehensive Systems Grant (ECCS) focusing on developmental screening of three year olds on Maui Island, maternal depression screenings of mothers, and family violence screening of families. The Ages and Stages Questionnaire-3 (ASQ-3) is the standardized screening tool that will be used with early childhood programs and will screen approximately 108-462 three year old children in the Maui community. These efforts will be shared with the Hawaii Title V Developmental Screening and Services Workgroup which is also facilitated by the ECCS Coordinator.

Hawaii's Developmental Screening and Services Workgroup will work to ensure the data sharing system is established for FHSD. The Workgroup has already identified the programs that will be a part of the data system. The next step to establishing the system is to ensure there are formal agreements between the programs, ensure parent consent and confidentiality will be secured, identifying the data elements that will be collected, developing the communications protocol and meeting frequency to discuss the findings of the data, and the development of a tracking form to monitor the data and progress.

Once the data sharing system is established, then Hawaii will be able to establish a baseline and use the data to improve linkages between the programs to better capture children who are screened and identified with a risk is receiving the services to support their optimal development.

The Title V Developmental Screening Workgroup will also oversee implementation of Title V Screening Efforts and the Policy and Public Health Coordination elements of the strategies. The main focus for FY 2017 is to continue to work with partners to implement the statewide system by being informed by what is happening at the community level to refine statewide policies, procedures and guidelines.

1. Systems Development
    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. Finalize screening, referral, and utilization policies for DOH programs
2. 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
3. Data Integration
    a. Develop data sharing system for FHSD programs on screening, referral, and follow up.
    b. Test screening, referral, and utilization data in three FHSD programs (Home Visiting, Hi'ilei, and EIS).
4. Service System
    a. Finalize Policy and Public Health Coordination Elements Ratings (PPHCER) and share with workgroup.
    b. Update PPHCER annually with workgroup.

A scale has been created to monitor/track progress made on the 5-Year plan strategies for developmental screening. The Title V Developmental Screening Workgroup will complete the scale annually as part of routine evaluation.

| Element | 0 Not met | 1 Partially Met | 2 Mostly Met | 3 Completely Met |
|---|---|---|---|---|
| **Systems Development** | | | | |
| 1. Develop guidelines and toolkit for screening, referral and services. | | | | |
| 2. Work with partners to develop infrastructure for ongoing training, technical assistance, and support for providers conducting developmental screening activities. | | | | |
| **Family Engagement and Public Awareness** | | | | |
| 3. Work with families and parent organizations to develop family-friendly material explaining importance of developmental screening and how to access services. | | | | |
| 4. Develop website to house materials, information and resources on developmental screening. | | | | |
| **Data Integration** | | | | |
| 5. Develop data system for internal tracking and monitoring of screening, referral, and services data. | | | | |
| 6. Develop process for on-going communication to review data findings and make adjustments for better outcomes for children and families | | | | |

**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. The HAAP mailing list has approximately 300 members including physicians and physician's aides and the HAAP Director has offered to allow DOH to use this mailing list to share information.

- 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.

**Challenges, Barriers**

While there is interest and activity by many groups focusing on developmental screening, it will be important to engage with the health plans and the Department of Human Services Medicaid agency since developmental screening is covered under both the Affordable Care Act (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 under the ACA, 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. The DOH does not have purview over agencies responsible for conducting developmental screenings (health care and early childhood providers) thus a general policy would not be effective. However, as the public health agency, standard policies, guidelines, or protocols would assist community providers and support the infrastructure for the system. This would also help the DOH work with Departments of Education and Human Services, which oversees public education, child welfare and the Medicaid program, to align efforts. 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.

**Priority Need: 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 Maternal Infant Early Childhood Home Visiting (MIECHV) grant and the federal Community-Based Child Abuse and Prevention (CBCAP) grant. These programs are housed in Title V's Maternal and Child Health Branch, Family Support and Violence Prevention Section (FSVPS). The program scope for FSVPS includes CAN Prevention, Sexual Violence Prevention, Domestic Violence Prevention, Home Visiting, and Parenting Support.

**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 and relates to the Title V child injury hospitalization national performance measure.

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

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

Non-fatal hospitalizations due to CAN represent a small subset of those captured by the Title V measure.

**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 communication, coordination, and collaboration and integration between programs addressing child wellness and family strengthening.

**Strategy Development**

The strategies reflect the work of the previous Governor's Executive Office of Early Learning Action Strategy initiative for "Nurturing and Safe Families". Although the Early Learning Action Strategy Initiative has moved out of the Governor's Office, its work continues as an important private-public partnership supported the non-profit sector. Portions of the Action Strategy planning framework has been utilized by the CBCAP grant. The strategies also reflect guidelines promoted by the Centers for Disease Control to prevent child maltreatment and are 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 leverage resources, reduce duplication of efforts, and promote a positive impact at the family and community level. Staff from both departments are currently developing an inventory of family programs from primary prevention to tertiary and intervention services.

The group has reviewed national frameworks to help develop a process to raise awareness and improve coordination of services that are currently available. This initiative, as well as activities in process at the MCH Branch, will assist the FHSD to formulate a CAN well-being plan for Hawaii.

The Home Visiting Services Unit (HVSU) within FSVPS receives State and Federal funds to maintain the Early Identification Program for the recruitment of participants prenatally and at birthing hospitals and referral into Home Visiting services. Funding is used to:

- Increase enrollment of prenatal women;
- Strengthen HV effectiveness in prenatal health and birth outcomes;

- Improve school readiness and referrals to community resources; and
- Promote sustainability through quality improvement.

The Home Visiting program continues to demonstrate success in meeting benchmark areas. These benchmarks include:

- Improve maternal and newborn health;
- Decrease child injuries;
- Decrease child maltreatment;
- Reduce emergency department visits;
- Improve school readiness and achievement; and
- Improve coordination and referrals.

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.

PSP also provides administrative support to the Safe Sleep Hawaii Committee and is an active participant in the National Institute for Children's Health Quality's Collaborative Improvement & Innovation Network (COIIN) to reduce infant mortality and sleep related infant deaths.

FHSD staff at the Neighbor Island District Health Offices (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.

**Evidence Based/Informed Strategy Measure**

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

**Plan for Plans for Application Year FY 2017 (10/1/16-9/30/17)**

- Title V, HV, PSP, CAN, Safe Sleep, and DHO program activities to prevent CAN will continue. Data will be collected to improve quality and assure outcomes will be documented.
- 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.

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 5-Year Plan or ESM will be made.

**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 prevention and family support assets, the key challenge is to improve coordination and collaboration. Fragmentation at all levels, starting with federal funding streams, promote separate program purposes, reporting, and data collection, even though programs often target the same families and communities.

**Child Health - Annual Report**

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

- NPM 7: Child Immunizations
- NPM 9: Child Protective Sealants
- NPM 10: Child Motor Vehicle Deaths
- NPM 13: Child Insurance Coverage
- NPM 14: Child Obesity
- SPM 3: Developmental Screening
- SPM 5: Child Abuse and Neglect
- SPM 11: Child Obesity Disparities

***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, and 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. CSHNP may refer parents to their primary care provider for immunizations.

***NPM 9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.***

The 2015 data indicates 12.8% of 6-9 year children enrolled in the Medicaid EPSDT program received sealants, exceeding the annual objective of 12%. At this time the state does not have population based data for this measure. The sealant placement rate continues to be low for this high risk group, far below the HP 2020 objective of 25.5%. With no civilian fluoridated water systems in Hawaii, dental sealants are an important preventive intervention.

In 2015, a third grade oral health Basic Screening Survey (BSS) was conducted to assess the oral health status of Hawaii's children. The clinical component of the survey included whether a child had untreated decay, existing restorations, missing teeth, or existing sealants. The third grade is the target elementary school population for the National Oral Health Surveillance System because it is a good proxy for the timely placement of sealants since first molars erupt on average in the first or second grade. This survey provided the first look at the extent of children with existing sealants throughout the state and will prove to be beneficial for program improvement over the coming years to provide comparative data.

In late 2015, a pilot school-based dental sealant program was initiated in Hawaii County in partnership with a local community health center. One of the goals of the project is to prove the feasibility of a school-based sealant program using a hygienist under general supervision of a dentist and recommending the placement of sealants without a dentist present. This challenges current state practice acts but could result in improvements in access to preventive services, such as sealants, to high risk children throughout the state by making school-based sealant programs financially feasible for community health center dental programs that currently must staff a dentist for these programs.

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

***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 2015 is 1.7 motor vehicle (MV) related deaths for children younger than 14 years (per 100,000 children). The Hawaii objective was nearly met. The indicators have remained largely stable over the past 5 year.

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 in Hawaii (2010-2014).

Due to small numbers, Hawaii injury data is often reported as an aggregate. Below is a table showing leading causes of fatal and serious injury by age group from the DOH Injury Prevention and Control Program.

## Leading causes of fatal and serious injuries among children in Hawaii, by age group, 2010-2014

| Rank | infants (123 total) | 1-5 years (147) | 6-15 years (202) | 16-17years (122) | total (594) |
|---|---|---|---|---|---|
| 1 | SUID 66 | falls 31 | suicide 41 | suicide 31 | falls 83 |
| 2 | homicide/ assault 14 | fires/ burns 22 | falls 30 | mvc*- occupant 28 | suicide 72 |
| 3 | falls 12 | drowning 17 | mvc*- occupant 22 | falls 10 | SUID 66 |
| 4 | fires/ burns 6 | mvc*- pedestrian 17 | struck by/ against 16 | mvc*- motorcyclist 10 | mvc*- occupant 58 |
| 5 | possible assaults 5 | homicide/ assault 11 | mvc*- pedestrian 14 | mvc*- pedestrian 8 | fires/ burns 41 |

*mvc = motor vehicle crash

- Sudden Unexplained Infant Death (SUID) 15 suffocations, 24 SIDS, and 27 "ill-defined and unspecified causes".
- Data sources: fatal injuries described from DOH death certificate database, serious injuries from HHIC records. Serious injuries are defined as those resulting in a hospitalization of 7 days or more, or patient transfer to another hospital.
- All injury categories are unintentional (or "accidental"), with the exception of homicides/assaults and suicides.
- Includes injuries to residents and non-residents.

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 2015, the estimated percent of Hawaii's children 0-17 years without health insurance is 3.4%, representing an estimated 10,354 uninsured children. The percentage went up slightly from 2014. The objective was not met; the rate compares favorably to the national rate of 6.5%.

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. As of April 2015, 25,601 children were enrolled in CHIPRA.

Hawaii's safety net includes 14 Federally Qualified Health Centers (FQHC) and their satellite sites. In 2014, the FQHCs provided care to 149,852 patients representing an increase of over 3,000 patients. Of these, 31% (45,274) were children under 18 years of age. The percent of children insured with Medicaid/CHIP increased to 57%, an increase of 4%. The percent of uninsured 0-17 year olds remained at 13%. 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. A total of 16 outreach worker trainings were conducted – four in each county. The trainings included practices and suggestions how to get the children signed up for insurance.

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: Percent of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85$^{th}$ percentile.***

The data for 2015 indicates 17.2% of WIC children ages 2-5 years were overweight or obese, a slight improvement from 2014. 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 partner 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 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 to promote the free educational material developed by the CDC. These resource materials were shared with early childhood providers and programs and their families at conferences and health fairs.

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 home visiting models in Hawaii. The Hawaii Home Visiting Models all use the Ages and Stages Questionnaire (ASQ) and ASQ-Social Emotional (SE) to monitor child development.

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.

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. Hi'ilei sends parents the ASQ to complete (either on paper or online) and returns information about the child's developmental scores and follow up information and activities to parents.

***SPM 5: Rate of confirmed abuse/neglect reports per 1,000 for children aged 0 to 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, and 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: Percent of Native Hawaiian and Other Pacific Islander (NHOPI) children, ages 2 to 5 years, receiving WIC services with a BMI at or above the 85$^{th}$ 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 2015 WIC data indicates 20.0 % of NHOPI children 2-5 years were overweight or obese. The 2015 WIC data is roughly 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.

Family Health Services Division (FHSD) continues to partner 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.

Partners in the project include the DOH Healthy Hawaii Initiative (HHI) and the University of Hawaii's Children's Healthy Living (CHL) Program for Remote Underserved Minority Population in the Pacific Region.

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.

**Adolescent Health**

**State Action Plan Table**

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

### Priority Need

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

### NPM

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

### Objectives

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

## Strategies

Collaboration: Develop partnerships with key community stakeholders to develop strategies to improve utilization of adolescent well care visits. • Work with partners to develop a pilot project or campaign to address the top 2 well-care visit barriers for parents and adolescents. • Explore clarifying billing mechanisms that support providers to offer a well visit during a visit for a chronic or acute condition.

Family Engagement and Public Awareness: Develop common messaging to describe the value of adolescent well care visit related to prevention and intervention for youth and parents. • Convene an Adolescent Health Steering Committee including FHSD/CSHNB/Children with Special Health Needs Program, ART Design Team, youth, and other community partners to develop a survey to determine adolescent and parent views of barriers to annual adolescent preventive care • Use input from Adolescent Health Steering Committee as well as from the ART & Science Workgroup (ASW) and other partners to provide messaging to providers, youth and families that speaks to the importance of routine adolescent well care.

Product Development: Disseminate medical home materials including the Adolescent Resource Toolkit (ART) as well as consumer materials on the reasons for and the methods to access adolescent preventive services. • Convene ART (Adolescent Resource Toolkit) & Science Workgroup including FHSD/CSHNB/Children with Special Health Needs Program, Hilopa'a Family to Family Health Information Center, Partners in Quality Health (management service organization (MSO) for leading Independent Physician Association in Hawaii), and American Academy of Pediatrics Medical Home Task Force to work on course content • Meet with new partners (e.g., specialty providers including inpatient psychiatric hospitals, DOH/Alcohol Drug Abuse Division, DOH/Developmental Disabilities Division) to obtain provider information, and develop referral algorithms • Compile and document state laws and policies related to adolescent health care including confidentiality, medical record documentation, consent/assent information

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

## ESMs

ESM 10.1 - Development and dissemination of a teen-centered, Adolescent Resource Toolkit (ART) with corresponding continuing education series (Science) to primary care providers to increase knowledge and skill in implementing the adolescent well-care visit

NOMs

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

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

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

NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

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

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

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

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

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

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

**Measures**

**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 | 2021 |
| Annual Objective | 83 | 83 | 84 | 85 | 86 | 86 |

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 82.2 % | 2.0 % | 83,403 | 101,416 |
| 2007 | 87.9 % | 1.6 % | 80,537 | 91,602 |
| 2003 | 72.3 % | 2.1 % | 71,854 | 99,342 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**ESM 10.1 - Development and dissemination of a teen-centered, Adolescent Resource Toolkit (ART) with corresponding continuing education series (Science) to primary care providers to increase knowledge and skill in implementing the adolescent well-care visit**

**Annual Objectives**

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Annual Objective | 15.0 | 21.0 | 33.0 | 42.0 | 48.0 |

**Adolescent Health - Plan for the Application Year**

**Priority Need: Adolescent Wellness Visits**

The 5-year needs assessment reaffirmed the importance of adolescent well-being as a priority issue. Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, 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 American Academy of Pediatrics Hawai'i Chapter 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. In addition, focus group with pediatric primary care providers demonstrated the need for further skill building

and lack of referral resources to address and refer for intervention for risk behaviors and behavioral health. Focus groups with Hawaii youth validate that teens have an alarmingly low awareness of the importance of preventive health care and many do not know their medical home provider.

Data from the National Survey of Child Health (NSCH) 2011-2012 showed 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 2015 Youth Risk Behavior Survey data showed that 44.3% of middle school aged adolescents and 61.9% of the high school teens saw a doctor for a check-up or preventive physical exam, showing slight declines from the 2011 survey. Improving access to and receiving preventive services by adolescents means enhancing certain preventive services such as screening, counseling to reduce risk, immunizations and the provision of general health guidance for adolescents. Practitioners can use clinic visits for routine examinations, such as pre-participation athletic evaluations and chronic disease management, to provide other preventive services like early identification of risk behavior and disease, reproductive health assessments, updating immunizations, or offering health guidance.

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

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

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

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

**Objective:**

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

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

**5-Year Strategies**

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

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

- Work with partners to develop a pilot project or campaign to address the top 2 well-care visit barriers for

parents and adolescents.
- Explore clarifying billing mechanisms that support providers to offer a well visit during a visit for a chronic or acute condition.

Strategy 2: Family Engagement and Public Awareness: Develop common messaging to describe the value of adolescent well care visit related to prevention and intervention for youth and parents.
- Convene an Adolescent Health Steering Committee including FHSD/CSHNB/Children with Special Health Needs Program, ART Design Team, youth, and other community partners to develop a survey to determine adolescent and parent views of barriers to annual adolescent preventive care
- Use input from Adolescent Health Steering Committee as well as from the ART & Science Workgroup (ASW) and other partners to provide messaging to providers, youth and families that speaks to the importance of routine adolescent well care.

Strategy 3: Product Development: Disseminate medical home materials including the Adolescent Resource Toolkit (ART) as well as consumer materials on the reasons for and the methods to access adolescent preventive services.
- Convene ART (Adolescent Resource Toolkit) & Science Workgroup including FHSD/CSHNB/Children with Special Health Needs Program, Hilopa'a Family to Family Health Information Center, Partners in Quality Health (management service organization (MSO) for leading Independent Physician Association in Hawaii), and American Academy of Pediatrics Medical Home Task Force to work on course content
- Meet with new partners (e.g., specialty providers including inpatient psychiatric hospitals, DOH/Alcohol Drug Abuse Division, DOH/Developmental Disabilities Division) to obtain provider information, and develop referral algorithms
- Compile and document state laws and policies related to adolescent health care including confidentiality, medical record documentation, consent/assent information
- Develop Hawaii based referral algorithms for behavioral health, substance use, sexual activity, and transition to adulthood
- Disseminate ART to 100 primary care providers serving adolescents

Strategy 4: Workforce Development: Increase resources, training and practice improvement support for adolescent health providers to provide teen-centered, well-care visits aligned to Bright Futures.
- Use input from ART & Science Workgroup to promote "Bright Futures" by developing teen-centered content modules on the following topics: Substance use, behavioral health, sexual activity, transition to adulthood, homelife, healthy eating, and transition across settings, repurposing the sports physical visit, and deliverying teen-centered care
- Deploy "Science" series to primary care providers and their staff using a variety of learning methods
- Consider dissemination of training and ART to jurisdictions and territories
- Establish baseline knowledge and comfort level for addressing adolescent issues with providers
- Assess for increase in knowledge and comfort level post training

**Strategy Development**

These strategies are derived from Center for Medicare and Medicaid Services (CMS) guidelines for states to increase adolescent preventive health care. The CMS guidelines also complement the national Office of Adolescent Health's Think, Act, Grow (TAG) Call to Action designed to promote adolescent health through a comprehensive approach with varied stakeholders including-parents; professionals; businesses and policymakers; and adolescents themselves. In addition, strategies were replicated from the past work of FHSD on deploying, *The Rainbow Book, Medical Home Resources Guide for Children with Special Health Care Needs*, a hallmark product of Hawaii services.

**Evidence Based/Informed Strategy Measure**

The Evidence Based/Informed Strategy Measure (ESM) selected for adolescent wellness is ESM 10.1 "Development and dissemination of a teen-centered, Adolescent Resource Toolkit (ART) with corresponding continuing education series (Science) to primary care providers to increase knowledge and skill in implementing the adolescent well-care visit." A data collection form was developed to track progress on the measure. This is a summary of the Data Collection Form that lists 17 strategy components:

**Adolescent Resource Toolkit (ART)**

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

**Continuing Education Curriculum Series (Science)**

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

**Outreach and Training**

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

Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 51. Scoring is completed by Title V staff, with input from ART & Science Workgroup. The data collection form is attached as a supporting document.

**Plans for Application Year Federal Fiscal Year 2017 (10/1/16-9/30/17)**

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 addition, this program year, Adolescent Health (AH) programs will require contractors to collect baseline data and ask program participants for the name of their health insurance carrier and the name of their physician. The Title V project team will also continue to explore ways to remove barriers that would prevent adolescents and their families from seeking preventive care visits.

Specific activiities planned for this fiscal year include:

- Finalize implementation plan with the ART & Science Workgroup.
- Conduct focus groups with adolescents to identify barriers and incentives to access preventive services, as well as the quality of interaction during adolescent well care visits.
- Assess parent and family awareness regarding adolescent preventive health care and barriers to accessing care to inform strategy development.
- Document complete inventory and clarity confidentiality and consent/assent state laws and in particular DOH agency policies
- Complete ART sections and training modules for Mental Health, Substance Abuse and Sexual Activity,

including referral algorithms and forms, visit materials, community resources and curriculum for “Bright Futures” visit expectations and brief action planning.
- Deploy and evaluate training for primary care on Mental Health, Substance Abuse and Sexual Activity modules

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

**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, in addition, the F2FHIC, (whose Director was the Co-Director for the MCH LEND Program and lead faculty for the needs assessment) has also completed supplemental interviews and a focus group with primary care providers. The F2FHIC 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 Association Research and Evaluation Foundation (HPAREF),
- the Hilopa`a Family to Family Information Center (F2FHIC),
- the American Academy of Pediatrics Hawaii Chapter,
- Partners for Quality Health, and
- the 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. In addition, health care transformation activities in the community with the largest health plan transitioning from fee for service to capitation for primary care may present a competing interest and place time constraints on primary care providers.

**Adolescent Health - Annual Report**

For the Adolescent domain Hawaii is reporting on the national performance measures which address the following issues:

- NPM 8: Adolescent Teen Births

- NPM 16: Teen Suicide

***NPM 08: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.***

The 2014 data is the latest data and is also provisional. The data indicate a rate of 9.7 live births per 1,000 teenagers aged 15-17 which met the 2014-15 State objective of 10 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 2015, 22.3% of those who ever had sex reported being currently sexually active which is lower than the 30.1% national average. However, among those who ever had sex, 51.6% did not use a condom at last sexual intercourse compared to 43.1% nationally in 2015, 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 (20.6%) and in Hawaii (19.9%).

The efforts to implement and promote teen pregnancy prevention (TPP) by replicating evidence based curricula has ended. Of the three federal TPP grant awards made to Hawaii in the past few years only the Personal Responsibility Education Program (PREP) and Abstinence Education Program (AEP) formula grants continue. The MCH Branch (MCHB) administers the PREP and AEP that targets youth at greatest risk of teen pregnancy (TP) and areas with high teen birth rates. Both formula grants were extended an additional year and new 3 year grants are in place to begin October 2016.

Hawaii County continues to exceed the state's average percentage of births to teen mothers. Because of the high teen birth rate, the PREP grant was used to contract the Hawaii County's Prosecuting Attorney's Office to provide county-wide community-based services. Hawaii's PREP grant targets teen pregnancy prevention services to teens who have dropped out of high school. The Teen Outreach Program (TOP®) is a teen club model for adolescents 15-18 years old. During this program year, 170 adolescents 10 to 18 years of age participated in after school community teen clubs on Hawaii Island. The Youth Challenge Academy (YCA), a 26 week residential facility in Hilo, formed 4 TOP clubs of 60 cadets and celebrated an 83% program completion rate. In late September, 5 YCA staff became certified facilitators after attending the 2 day TOP® facilitator training session provided by Hawaii County. TOP® is a teen club community-based program model with an integrated teen pregnancy prevention, life skills and community service learning curriculum.

The AEP grant is in its final year on Oahu. Through the Boys and Girls Club of Hawaii, their proprietary SMART Moves abstinence curriculum was offered in their after school programs at the Spalding Clubhouse in urban Honolulu, Hale Pono in suburban/rural Ewa Beach, the National Football League Youth Education site in Nanakuli, and their Waianae Clubhouse both in rural Oahu communities with a large Native Hawaiian population. Pre-post surveys for more than 280 participants showed that more than 71% of participants had increased knowledge, attitudes, behaviors and skills on the sexual health content presented.

MCHB's Family Planning Program (FPP) health educators worked in collaboration with FPP contract providers and the Department of Education's (DOE) health education resource teachers to adapt existing evidence-based, reproductive health curricula to be used in the schools. The 10 FPP health educators provided 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 aged 15 through 19.***

The provisional data for 2015 is 8.2 suicide deaths per 100,000 youth aged 15-19. The state objective of 8 was virtually 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 2015, 16.0% of Hawaii's high school youth reported considering attempting suicide, similar to 17.7% of their peers nationally. However, there was no significant increase in reported suicide attempts (10.5%) as compared to their mainland counterparts at 8.6%.

The Prevent Suicide Hawaii Task Force (PSHTF) is under the guidance of the DOH 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 military forces are also well represented and continue to provide suicide prevention awareness and training opportunities to the military communities. 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 which the Title V neighbor island staff participate in, includes a consortium of safeTALK trainers on Hawaii Island. The intent of this group is to collaborate with community-based agencies to have safeTALK, Applied Suicide Intervention Skills Training (ASIST) or Connect suicide prevention training become an integral part of communities, including within the DOE system.

**Children with Special Health Care Needs**

**State Action Plan Table**

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

## Priority Need

Improve the percentage of youth with special health care needs ages 14-21 years who receive services necessary to make transitions to adult health care.

## NPM

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

## Objectives

By July 2020, increase the percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care to 39% [Baseline: Hawaii 37.3%, National Survey of CSHCN (NSCSHCN) 2009/10]

## 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 disseminate transition materials to other agencies to incorporate into their programs.

- Promote importance of transition to adult health care.

• Staff development: Personnel must be knowledgeable and competent in order to guide the discussion and planning in transition issues. Staff should be given the opportunity to participate in webinars, trainings, as well as national conferences to obtain the most current information.

• Strengthen CSHNP Transition infrastructure by establishing standardized timelines, forms, and data collection methods.

• Potential opportunities: Investigate the inclusion of transition in other FHSD services/contracts.

## ESMs

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

## NOMs

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

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

### Measures

**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 | 2021 |
| Annual Objective | 36 | 36 | 37 | 38 | 39 | 39 |

**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 | 37.3 % | 3.4 % | 4,714 | 12,643 |
| 2005_2006 | 39.4 % | 3.3 % | 5,024 | 12,766 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 10.0 | 14.0 | 18.0 | 22.0 | 24.0 |

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

**Priority Need: Transition to Adult Health Care**

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:** 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.

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.

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

**Objective**: By July 2020, increase the percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care to 39%. [Baseline: Hawaii 37.3%, National Survey of CSHCN (NSCSHCN) 2009/10]

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

**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 Hilopa`a 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 disseminate transition materials to other agencies to incorporate into their programs.
  - Promote importance of transition to adult health care.
- Staff development: Personnel must be knowledgeable and competent in order to guide the discussion and planning in transition issues. Staff should be given the opportunity to participate in webinars, trainings, as well as national conferences to obtain the most current information.
- Strengthen CSHNP Transition infrastructure by establishing standardized timelines, forms, and data collection methods.
- 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. 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.

**Evidence Based/Informed Strategy Measure**

The Evidence Based/Informed Strategy Measure (ESM) selected for transition to adult is focusing on integrating the *Got Transition's Six Core Elements of Health Care Transition 2.0* into the Title V CSHN Program services to support youth/families in preparing for transition to adult health care.

The actual measure is "The degree to which the Title V Children and Youth with Special Health Needs Section (CYSHNS) promotes and/or facilitates transition to adult health care for YSHCN." A data collection form was developed to track progress on the measure. This is a summary of the Data Collection Form that lists 11 strategy components organized by the Six Core Transition Elements.

**Transition policy**

1. Develop a CYSHNS transition policy/statement that describes the transition approach, including consent/assent.
2. Educate staff about the transition approach, policy/statement, Six Core Elements, and roles of CSHNP, youth/family, and pediatric/adult health care team in transition.

**Transition tracking and monitoring**

1. Establish criteria/process to identify/track transitioning youth in CSHNP database.
2. Utilize flow sheet or database to track youth's transition progress.

**Transition readiness**

1. At least annually assess transition readiness with youth and parent/caregiver, beginning at age 14, to identify needs related to the youth managing his/her health care (self-care).
2. Jointly develop goals and prioritized actions with youth and parent/caregiver, and document annually in a plan of care.

**Transition planning**

1. At least annually update plan of care, including readiness assessment findings, goals, and prioritized actions.
2. Prepare youth and parent/caregiver for adult approach to care before age 18, including legal changes in decision-making, privacy and consent; self-advocacy; access to information; and insurance continuity.
3. Develop/implement referral procedures to adult service agencies.

**Transfer of care**

1. Prepare youth and parent/caregiver for transferring to adult health care provider and planning for health insurance coverage as an adult.

**Transition completion**

1. Contact youth and parent/caregiver, when CSHNP services end, to confirm having an adult health care provider and health insurance coverage, or provide further transition guidance.

Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 33. Scoring is completed by CSHNP staff, with input from Hilopaa Family to Family Health Information Center. The baseline for 2016 was 4. Objectives were set by the CYSHNS staff based on their expected progress, considering the work and program changes that are needed.

See Form 10C for the Detail sheet. A copy of the data collection form is in the report Supporting Documents.

**Plans for Application Year Federal Fiscal Year 2017 (10/1/16-9/30/17)**

Future work will center on establishing/continuing partnerships to increase the capacity of providers to support transition services including Title V programs.

- Continue transition fairs for youth and their families, modeled after Maui county's *Footsteps to Transition/Big MAC (Moving Across Community)* event as well as other interagency transition outreach efforts.
- Participate in other large well-established events, such as the Special Parent Information Network (SPIN) Conference, in which participants include youth with special needs and their families.
- Support professional development opportunities to increase workforce competencies to address transition issues via webinars, trainings, and conferences.
- Collaborate with the FHSD/Adolescent Health Program to integrate transition planning into the program's established stakeholder networks and service contracts.
- Collaborate with Hilopaa and partner physician organization (PO) PMAG on integrating Transition Planning in pediatric primary care settings with PO Care Coordinators. This initiative, "Kapili Kokua", helps broaden the number of YSHCN with a facilitated transition planning process.
- Develop informational materials to use with younger-aged children and their families.
- Promote and/or facilitate transition to adult health care for YSHCN needs age 14-21 years receiving Children with Special Health Needs Program services. See Form 10C for details.

FHSD will 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 5-Year Plan or ESM will be made.

**Factors Contributing to Success**

Encouragement from the Federal level to include transition in agency services has helped heighten recognition that good transition planning and execution improves adult outcomes. The *2020 Federal Youth Transition Plan: A Federal Interagency Strategy* reinforces the importance of interagency collaboration to improve the provision of transition services to youth with and without disabilities.

Resources are available (and free) for health providers, community, and youth/family use. The national *Got Transition* website has current transition materials, including its *Six Core Elements of Health Care Transition 2.0*. Transition booklets, tips, and recommendations can be found on various national websites. Hawaii's own Hilopaa has a line of materials--Transition Workbook, Personal Health Record, and various checklists for providers.

The state Department of Education (DOE) requires that all high school students have a Personal Transition Plan to transition from high school to college and careers. DOE co-sponsors and hosts transition events. The Hawaii

Maternal Child Health Leadership Education in Neurodevelopmental & Related Disabilities (MCH LEND) Program 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.

- Busy-ness: Families are Busy---with life, work, sports, their other children, etc. There are physical, financial, and emotional tolls of having a family member with a special care need. Health providers and other community providers are Busy. The concept of transition may not be a first priority.
- It takes time to coordinate and organize discussions with and between multiple service providers

The process needs to be individualized with youth input into the process

**Children with Special Health Care Needs - Annual Report**

For the Children with Special Health Care Needs 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 Children with Special Health Care Needs (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 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.

The Hawaii Early Intervention Coordination Council (HEICC) advises the Department of Health (DOH) regarding early intervention 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 child with special health care needs.

The Early Intervention Section (EIS) in the Children with Special Health Needs Branch (CSHNB)/DOH supports families attending conferences and trainings by paying registration fees and, if needed, airfare and ground transportation for Neighbor Island travel to Oahu. EIS continues to obtain input and feedback from families through meetings, committees, and an annual family outcome survey.

The Newborn Hearing Screening Program (NHSP) in CSHNB/DOH provides parent support to families with children who did not pass newborn hearing screening or who had confirmed hearing loss. Parent support includes assistance with scheduling hearing evaluations, financial support for hearing evaluations if needed, resource information, and provision of trainings. 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 collaborated with the H&V Hawaii Chapter and EIS to offer parent education and parent support activities. The “Hawaii State Resource Guide for Families of Children with Hearing Loss” was published in 2015.

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. 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 Children with Special Health Needs Program (CSHNP) in CSHN Branch/DOH has a family resource handbook that includes a Transition section to develop a Family Individual Plan (FIP) for services. The Transition Checklist tool and FIP are developed together with children/youth 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), Hilopaa Family to Family Health Information Center, Developmental Disabilities Division, Special Parents Information Network (SPIN), Community Children's Council (CCC), and Best Buddies to host annual transition fairs in the community.

In East Hawaii, the CSHNP social worker assisted with the planning and coordination of the first annual East Hawaii Disability Legislative Forum held on August 20, 2015 and the 10th annual Children and Adolescent Mental Health Awareness Day event, Malama Da Mind, held on May 8, 2015. For the forum, a panel of legislators and DOH program staff discussed employment, housing, and transportation issues as related to the disability community. Information on the Achieve a Better Life Experience (ABLE) Act, the Workforce Innovation and Opportunity Act (WIOA), and Centers for Medicaid and Medicare Services rule changes were shared. At the Malama Da Mind event, 28 vendors participated, sharing information about their agency services. "Malama" means "to protect/care for" in Hawaiian. Free chili and rice, entertainment by school aged children's groups, and door prizes helped draw over 250 people to this event.

In West Hawaii, the CSHNP social worker trained as a class leader for GRANDcares, which is a pilot program supported by a grant through the University of Hawaii at Manoa and Colorado State University. The GRANDcares project and the program for children with special needs has three program objectives: 1) enhance grandparent's (caregiver) parenting skills and self-care practices; 2) promote youth participants' self-efficacy and leadership skills; 3) strengthen service providers' abilities to support grand families and families of children with special needs. This would be in the form of professional development, mostly webinar series. The definition of grandparents is broad and could include many forms of custodial descriptors. At this time, there is a question about Resource families being included in the grant. The grant also supports another strand for children with special needs.

CSHNP worked 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 creating 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 signed into law (Act 213, 2015) 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 resources.

### *NPM 03: The percent of CSHCN age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.*

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

The Children with Special Health Needs Program (CSHNP) in the Children with Special Health Needs Branch

(CSHNB) supports medical homes by assisting families with access to specialty services. CSHNP provides information and referral, outreach, service coordination, social work, audiology and nutrition services for CSHCN age 0-21 years. Pediatric cardiology, neurology and nutrition clinics are provided on neighbor islands where those services are otherwise unavailable. Financial assistance for medical specialty services and neighbor island travel is provided to eligible children as a safety net for those who have no other resources. CSHNP social workers assist in supporting the neighbor island clinics. In conjunction with client medical homes, the West Hawaii CSHNP social worker supports community cardiac clinic services.

Challenges in accessing medical specialty services on the neighbor islands include a shortage of providers and the high cost of transportation to Oahu. In coordination with the medical home, CSHNP staff assist in arranging for travel to Oahu for pediatric specialty services for neighbor island families who otherwise may have difficulty accessing services.

CSHNP is part of the Kapiolani 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.

Title V workgroups on early childhood development screening and transition to adult health care continue their efforts to improve access to services for families in collaboration with community partners.

The Newborn Metabolic Screening Program in CSHNB provides metabolic screening to all newborns, collaborates with the medical home for follow up, and has “Hawaii Practitioner’s Manual” posted on its website.

The Early Intervention Section (EIS) in CSHNB includes care coordination and involves the medical home in the Individual Family Support Plan conferences with family consent.

The Genomics Program in CSHNB 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 Genomics Section Supervisor is the Director for the Western State Genetic Services Collaborative (WSGSC), which 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.

Hiilei Hawaii was created in 2013 as a safety net developmental follow along program for young children, in response to EIS changes in eligibility for early intervention services. Hiilei works with the Hilopaa Family to Family Health Information Center as needed in involving the medical home when there are referrals to early intervention services or to Department of Education (DOE) preschool special education.

The Early Childhood Comprehensive Systems (ECCS) Coordinator is one of the co-leaders for the Early Childhood Action Strategy team addressing the health and development of children birth to age 8 years. The key role of the medical home is recognized in planning activities.

The Women, Infants and Children (WIC) Services Branch works to assure all clients have a medical home and insurance coverage. Referrals include to the Health Insurance Exchange and federally qualified health centers for care.

***NPM 04: The percent of children with special health care needs age 0 to 18 whose families have adequate private and /or public health 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 CSHCN 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 Branch (CSHNB)/Children with Special Health Needs Program (CSHNP) service coordinators assisted CSHCN and their families obtain and maximize use of health coverage. As a safety net, CSHNP provides 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 Hawaii islands.

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% poverty guidelines are eligible for Medicaid services under QUEST Integration (QI) managed care. QI combines and replaces the QUEST and QUEST Expanded Access (QExA) programs. QI includes more health plan choices for aged, blind or disabled (ABD) individuals; greater ability for a beneficiary to remain with the same health plan upon turning 65 or developing a disability; and expanded access to home and community-based services to prevent decline to institutional level of care. Expanded Medicaid eligibility under the Affordable Care Act (ACA) uses new Modified Adjusted Gross Income (MAGI) rules for income which eliminate the asset test for non-ABD individuals and eliminate disregarded income types by increasing the MAGI poverty guidelines to 308%. This increase in coverage helps families with income in the 300-308% range.

CSHNP, Hawaii District Family Health Services Coordinator, cardiologist, and West Hawaii Keiki Health Clinic collaborated to expand access of 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.

CSHNB funded neurology, genetic and nutrition clinics on Hawaii island; genetic and nutrition clinics on 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 Medicaid-eligible children are in part reimbursed under a Memorandum of Agreement (MOA) between the Department of Human Services (DHS) and Department of Health (DOH). EI services include therapies, interventions, and services to address five areas of development – communication, cognitive, physical, social/emotional, and adaptive development.

In 2009, CSHNP identified a disparity of insurance coverage for children requiring orthodontic treatment as a result of an oral-facial birth defect such a cleft lip and palate. While the State Medicaid and Tricare insurances already provided coverage for medically necessary orthodontic treatment, commercial medical plans did not and parents were required to pay out of pocket for up to three phases of orthodontic treatment. Over a period of six years, CSHNP developed partnerships and collaboration among parents, community agencies, public and private sectors on legislation to eliminate the insurance disparity. The result was Act 213 which was signed into law by Governor David Ige on July 2, 2015. Act 213 requires commercial insurance plans to provide a medical benefit of up to $5,500 per treatment phase for medically necessary orthodontic treatment for children with oral-facial birth defects, effective January 2016. These children may require two to three phases of orthodontic treatments by the time they reach 18-21 years of age. Hawaii is among seventeen states that requires medical benefit under commercial medical insurance plans.

CSHNP continues to financially assist families with hearing aid purchase and hearing related services. Health insurance coverage for hearing aids in Hawaii varies. Consumers are left with large co-payments, which can make the purchase of hearing aids a financial hardship. Some insurance companies do not cover hearing aid purchase at all or only cover a small amount. Also, all health insurance companies in Hawaii do not cover bone-anchored hearing aids, which is amplification for people who have atresia, microtia or other middle ear disorder that prevents them from benefiting from a standard hearing aid. Families must pay the full amount of the bone-anchored hearing aid. Legislation was introduced in 2015-2016 to mandate that health insurance companies in Hawaii cover at least $1500 for standard and bone-anchored hearing aids; however, it did not pass.

The Genomics Section 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. The WSGSC continues 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 Genomics Section also continues to work with third party insurers to improve reimbursement for telehealth genetic consultations and newborn screening services.

***NPM 05: Percent of children with special health care needs age 0 to 18 whose families can easily access community-based services.***

Data from the National Survey of Children with Special Health Care Needs (CSHCN) indicates that 71.5% of Hawaii CSHCN 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 (EIS) 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 developmental delays 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. Services are provided in the child's natural environment which includes the family's home, family caregiver's home, child care setting, and community setting.
- 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.
- Genomics Section and state/community partners work to assure the availability and accessibility of quality genetic services in the state. The Section with the Western States Genetic Services Collaborative (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 Genomics Section, Kapiolani Medical Center, Queen's Medical Center, and University of Hawaii 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 WSGSC projects and evaluation of approaches utilized.

Neurotrauma Supports, in Department of Health (DOH)/Developmental Disabilities Division, addresses the 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.

FHSD participates in the Keiki Caucus, which is a committee formed by legislators to address the needs of children. Members include government and community representatives. Legislation regarding health, education and child safety are introduced every year. CSHNB also participates in the Deaf and Blind Task Force. A bill to form a working group to address the language needs of deaf and hard-of-hearing children receiving EI services passed this legislative session.

EIS providers refer children and families to community programs based on family's interest. Community programs

include preschools, child care services, and community playgroups.

CSHNP schedules, coordinates, and assists in community-based medical clinics in providing specialty medical care to neighbor island children who do not have access to resident specialty care on island. In order to fill this gap, Nutritionist, Geneticist, Genetic Counselors, Neurologists, and Cardiologists from Oahu travel to the neighbor island clinics to conduct the clinics.

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 leads the Vision Screening Task Force that is setting statewide vision screening protocols. Team members include DOH, Department of Education (DOE), doctors, and community organizations.

CSHNP partners with Special Olympics Hawaii and Developmental Disabilities Division to ensure that Summer Games athletes have access to medical care.

CSHNP partners with the Hawaii Lions Club in providing hearing and vision screening in schools throughout Hawaii.

CSHNP Social Worker participates in the Hiilei Program. Children age 0-5 years who do not qualify for EI services are periodically monitored using the Ages and Stages Questionnaire.

Kauai CSHNP participated in an island-wide anti-bullying campaign, in partnership with DOE, sports organizations, and local businesses.

Hilo and Kona CSHNP participated in the Disability Legislative forum, which is a partnership of state and community groups to develop legislation and policy for people with disabilities.

For the Title V priorities of early childhood development/screening and transition to adult health care, two Title V workgroups focus on system-building to develop resources, provide information, and incorporate the issues in state planning and policy initiatives.

***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.***
***SPM 09: 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)***
The foundation for transition begins in early childhood. The Department of Health (DOH) Children with Special Health Needs Branch (CSHNB) Early Intervention Section (EIS) instills the importance of transition planning and support for children with developmental delays from the initial meeting. Data from the National Survey of Children with Special Health Care Needs 2009/2010 show that 37.3% of Hawaii youth with special health care needs (YSHCN) received transition services, compared to 40% nationally. The National Survey also indicated that 34.5% of Hawaii YSHCN age 12-17 years 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 Supplemental Security Income (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 Hilopaa Family to Family Health Information Center (F2FHIC) 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 Quality Improvement using Plan, Do, Study, Act (PDSA) 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 a visually-appealing ”Footsteps to Transition” handout. Based on the Hilopaa 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. The workgroup developed an additional handout, “The Student Disability Services in Higher Education”, which listed 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 Moving Across the Community (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 and youth panel speakers. Agency/program exhibits helped youth and families access transition services. All families received a Hilopaa Transition Workbook and Personal Health Record.

The events are conducted in partnership with the Department of Education (DOE), Title V, Hilopaa F2FIC, the Arc, Special Parent Information Network (SPIN), Community Children’s Councils, DOH Developmental Disabilities Division (DDD), Department of 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 Children with Special Health Needs Program (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/caregivers, 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, including other specialist providers, and obtaining medical insurance to enable YSHCN 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 independently) 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.

On Oahu, CSHNP participates in the annual SPIN Conference, sharing information about transition planning and services. Roughly, 500 families attend this major event. CSHNP’s interactive display includes a “Wheel of Fortune” spin the wheel game, which is comprised of transition topics/questions that family/youth “contestants” have to answer. Small prizes were 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.

**Cross-Cutting/Life Course**

**State Action Plan Table**

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

### Priority Need

Improve the oral health of children and pregnant women.

### NPM

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

### Objectives

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

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

### Strategies

Develop program leadership and staff capacity

Develop or enhance oral health surveillance

Assess facilitators/barriers to advancing oral health

Develop and coordinate partnerships with a focus on prevention interventions

Develop plans for state oral health programs and activities

### ESMs

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

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

## NOMs

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

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

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

## Priority Need

Improve access to services through telehealth

## SPM

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

## Objectives

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

## Strategies

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

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

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

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

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

### Priority Need

Improve family and consumer engagement in Title V Programs.

### SPM

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

### Objectives

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

### Strategies

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

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

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

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

### Priority Need

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

### SPM

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

### Objectives

By July 2020, increase meaningful partnerships with FHSD Programs

### Strategies

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

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

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

**Measures**

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 38.0 | 40.0 | 41.0 | 42.0 | 45.0 | 45.0 |

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2012 | 42.5 % | 1.7 % | 7,823 | 18,403 |
| 2011 | 37.0 % | 1.6 % | 6,817 | 18,448 |
| 2010 | 33.8 % | 1.6 % | 6,122 | 18,126 |
| 2009 | 33.5 % | 1.5 % | 6,035 | 18,010 |

**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

**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 | 2021 |
|---|---|---|---|---|---|---|
| Annual Objective | 84.0 | 84.0 | 85.0 | 86.0 | 87.0 | 87.0 |

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 83.1 % | 1.2 % | 236,960 | 285,187 |
| 2007 | 86.9 % | 1.1 % | 225,601 | 259,718 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | Yes | Yes | Yes | Yes | Yes |

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

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | Yes | Yes | Yes | Yes | Yes |

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

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

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

The five-year needs assessment reaffirmed the importance of oral health for adults and children as a priority issue. Oral health was identified in 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 Department of Health 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.

**Objectives:**

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

The 5-year plan objectives were developed using 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 taken from the Family Health Services Division (FHSD) 5-Year Centers for Disease Control oral health state infrastructure building grant The infrastructure grants are provided to build public health capacity to reduce the prevalence of oral health disease in the population. FHSD, which is the Title V agency, is responsible for the public health services for the DOH state oral health program (SOHP). FHSD works closely with the Developmental Disabilities Division, which houses direct service dental clinics on Oahu designed to service primarily adults with Intellectual/Developmental Disabilities. DDD is the only program with dental professionals in the DOH.

**Evidence Based/Informed Strategy Measure**

There are two Evidence Based/Informed Strategy Measures (ESM) selected for oral health. The first measure (ESM 13.1) focuses on one of the key strategies for building the oral health infrastructure for the Department of Health - assuring the program has qualified leadership, a dental professional and staff with public health skills. The actual measure is “The establishment of leadership for the State Oral Health Program under the direction of a dental professional and staff with public health skills.” The measure is tracked by a Yes or No. Yes refers to the completion of the 6 steps to assure leadership is provided for the SOHP. No indicates the steps are still in progress. See Form 10C for the Detail sheet.

The second ESM 13.2 focuses on the completion of a pilot demonstration project for teledentistry. The project is located at three early childhood program sites and may also extend services to pregnant women. This measure also supports one of Hawaii’s State Performance Measures to promote telehealth in Title V programs. The actual measure is “Completion of a teledentistry pilot project at three early childhood settings to reach underserved children and pregnant women.” The measure is tracked by a Yes or No. Yes refers to the complete of the 17 project activities. No indicates the project is still in progress. See Form 10C for the Detail sheet.

Once the activities for each of the ESM are completed, new measures will be developed and included in the Title V 5-year plan.

**Plans for Application Year Federal Fiscal Year 2017 (10/1/16-9/30/17)**

- Hiring and conducting leadership orientation for the Dental Director and Program Manager to assure state public health leadership for the state oral health program.
- Publish and disseminate the third grade Oral Health Basic Screening Survey final report and disseminate to stakeholders.
- Plan and coordinate a Head Start/Early Head Start Oral Health Basic Screening Survey.
- Publish findings of Pilot school dental sealant project (evidence based strategy) to identify cost-effective, sustainable service delivery/financing models.
- Disseminate findings of pilot oral health co-location project at WIC and consider plans to expand to other WIC clinic locations.
- Complete teledentistry pilot project at three early childhood sites.
- Integrate oral health promotion for both women and children into WIC services, Early Head Start, and other early childhood facilities.
- 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 currently has posted vacancies in all oral health program positions. Interviews for both positions are in the process of being scheduled. Once the positions are filled, the Association of State and Territorial Dental Director (ASTDD) will provide orientation and training of the new Dental Director and Program Manager. 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. The final report is planned for publishing in August 2016. The report confirms that Hawaii third graders have the highest rate of caries in the U.S. 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's Hawaiian Islands Oral Health Task Force implementation of a second year CMS State Innovation Model (SIMS) grant. One of the SIM focus areas is oral health. The DOH Deputy Director is a co-leader for the Hawaiian Islands 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 awarded in 2015. The lead for this project is the DOH Planning Office. DOH partnered with an existing FQHC dental program in Hawaii County to identify a cost-effective and, therefore, sustainable service delivery and financing model for the provision of oral health services in a school setting. A report on the project is forthcoming. Additional sites may also pilot a sealant program. DOH will work with Medicaid to implement policies allowing reimbursement for oral health services delivered in public health settings, including schools.

Funding from Hawaii Dental Services has also afforded the opportunity for a pilot study in the delivery of diagnostic and preventive services through the use of teledentistry technology. Teledentistry helps reach and provide diagnostic and preventive dental services for underserved populations that traditionally do not get dental care until they have advanced disease, pain, and infection. Oftentimes, accessibility to preventive services is more readily available when provided by hygienists in a public health setting. Through this model of care, dentists are not required to leave the clinic setting but instead through store and forward technology, have the ability to diagnose on their own time, while not delaying the timely preventive interventions that can be provided by hygienists in a low-cost setting. With the use of radiographs and photographs, dentists are able to diagnose conditions remotely while children and pregnant mothers receive preventive services in a timely manner. Diagnosis through teledentistry also affords the opportunity to refer patients in a timely manner and reduces the costs associated with the "high cost dental suite."

The DOH DD Division's Health Hospital and Community Dental Services Branch is the lead for the project and is partnering with the Pacific Center for Special Care (PCSC) to provide technical assistance in developing this program.

Telehealth is an important priority for the Governor and Hawaii's legislature. In 2014 the Legislature passed Act 159 for face-to-face and telehealth reimbursement parity. In 2016 the Governor signed Act 226 requiring the state Medicaid program to reimburse for telehealth services and ensures telehealth is covered when originating in a patient's home and other non-medical environments.

Orientation to the needs of the population and the introduction to how this mode of providing dental services can meet that need have been presented to a wide variety of community partners, including FQHC dental directors, legislators, oral health advocates, and others. Funding at this time through HDS is one year with the ability for additional years of funding if necessary. Memorandums of understanding have been finalized for three early learning pilot sites. Program protocols and policies have been modeled off of PCSC's "Virtual Dental Home" pilot programs. Dental equipment and teledentistry software and hardware have been purchased. Training for providers, case managers, and other site staff is in process and clinical care is scheduled to start at all three sites between July-September 2016. Evaluation plans are under development and evaluation will be ongoing. Once all pilot sites are completed, a report will be provided outlining the results of the program and economic feasibility analysis.

One of the projects to improve the oral health of pregnant women will target WIC clients and Early Head Start.

FHSD contracted with the University of Hawaii, School of Nursing and Dental Hygiene (SONDH) to survey WIC clients of oral health attitudes, behaviors, and beliefs to identify common barriers to oral health care. In addition, oral health education was provided to WIC clients. The SONDH developed a report outlining 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 explore whether Medicaid can increase the reimbursement FV rate to pediatric providers. Hawaii's rate is one of the lowest in the U.S.

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

**Factors Contributing to Success**

The State Oral Health Program (SOHP) has made significant progress in several strategic areas over the past few years. One major milestone for the SOHP this year was its first major oral health data publication in August 2015. The Hawaii Oral Health Key Findings report was completed and distributed to key policymakers, healthcare agencies, and community stakeholders. The report was well received. Following the report recommendations, legislation was introduced in 2016 to support funding for restoration of a Medicaid adult dental benefit. The report was endorsed by the Governor's State Health Transformation Office and incorporated into the Hawaii Health System Innovation Plan elevating oral health as a key health care systems priority for the state.

The second exceptional milestone was the completion of Hawaii's first statewide Basic Screening Survey of third grade children. The BSS data collection and analysis were completed. The report was written by ASTDD consultant, Kathy Phipps, in consultation with the SOHP and will be ready for distribution in August 2016. Being one of the last five states to complete a 3rd grade BSS, Hawaii was finally able to report BSS data to the CDC National Oral Health Surveillance System (NOHSS) for the first time in November 2015.

Securing dedicated staffing for the SOHP is the top priority for the Hawaii Department of Health (HDOH). Although a Dental Director has not been hired, the SOHP made substantial progress in this area. A full-time Program Specialist position has been created and is under active recruitment. Additionally, in an effort to increase leadership/staffing capacity, the SOHP entered into a partnership with the New York University-Lutheran Medical Center (NYU-LMC) Dental Public Health (DPH) Residency program which recently established a program in Hawaii. Since November 2015, the SOHP has been working with new resident, Dr. Jennifer Domagalski, and faculty advisor, Dr. Steven Silverstein. Both dentists have been providing technical assistance (TA) and guidance for publications/reports, project planning, and policy development. In February 2016, the SOHP met with Dr. Jay Balzer, director for the residency program, and agreed to offer the SOHP as a possible placement for future residents. Without a dental school and given barriers to recruit a dental director, this partnership has helped to expand the SOHP leadership capacity.

Locating the oral health program in the MCH Title V agency, with a culture of working in collaboration and partnership, helped facilitate:

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

FHSD also provided access to extensive resources including 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 (particularly from ASTDD) and resource availability.

**Challenges, Barriers**

The primary barrier to progress for the SOHP continues to be lack of dedicated public health leadership and staffing to work on building the SOHP capacity. Although securing dedicated staffing is the top priority for the SOHP, there have been major challenges and barriers to achieving greater progress in this area. The SOHP received 28 inquiries and 11 applications for the position. Of those, three failed to meet the Hawaii licensing requirement. To date, a total of six candidates were interviewed. An offer was made; however, the candidate declined due to family reasons. A second candidate was unable to start till October 2016 due to prior commitments, but will reapply in the fall. The position remains under recruitment and applications are still being received.

There are three major barriers associated with filling the Dental Director position: a low salary when compared to potential earnings in private practice, restrictive dental licensing requirements within the state of Hawaii, and a limited number of dentists with public health training and experience. Because Hawaii does not have a dental school, the pool of qualified dentists is limited to practicing clinicians. Other contributing factors are the relative geographic isolation of the state from the continent and the high cost of living.

**Priority Need: Telehealth**

Expanded use of telehealth technology was identified as a priority in the Title V 5-year needs assessment. With the reduction in personnel resources, increases in travel costs, and availability of the internet, HIPAA compliant software, and affordable devices, telehealth can be one of the tools to increase access to services, education, and training for families and providers while reducing costs and travel time especially for neighbor island and rural communities.

The National Survey of Children with Special Health needs show that Hawaii children with special health care needs (CSHCN) have more difficulty accessing specialist care (17.3%) compared with non-CSHCN (3.3%). (Data source: NSCH 2011/12). The State of Hawaii Community Health Needs Assessment notes that fewer services are available in rural parts of Oahu and Neighbor Islands, and that many specialized services are not available on each island, requiring costly air transportation to receive needed care. Use of telehealth in Hawaii for provision of genetics and behavioral health services have families and providers reporting high satisfaction with use of the technology and services provided.

Over the past year, there has been an increase in the statewide efforts towards increasing the use of telehealth by programs within the Department of Health (DOH), statewide hospitals, the University of Hawaii, state legislators, and our Congressional representation. These efforts have been supported by the HRSA funded Pacific Basin Telehealth Resource Center based in the University of Hawaii that works to help stakeholders collaborate on telehealth activities.

Hawaii's Congressional Senator Brian Schatz and his aides met several times with Department of Health, University of Hawaii, and hospital representatives to discuss ways to increase the use of telehealth in Hawaii. Senator Schatz also convened a statewide meeting in January 2016 to discuss current issues in telehealth and he introduced federal legislation to support more telehealth activities under the Medicare rules.

In 2014 the Legislature passed Act 159 for face-to-face and telehealth reimbursement parity. In 2016 the Governor signed Act 226 requiring the state Medicaid program to reimburse for telehealth services and ensures

telehealth is covered when originating in a patient's home and other non-medical environments.

Within the DOH, the Director has made increasing the use of telehealth as one of her top priorities in the new strategic plan for the Department. DOH is also being funded by the Association of State and Territorial Health Officers for a joint project with Alaska to explore successful telehealth activities. Within the Family Health Services Division (FHSD) there is ongoing support for efforts to implement or increase telehealth activities for genetics, newborn screening, early intervention, and home visiting activities. As part of these efforts, workforce training about telehealth is being developed.

Other FHSD telehealth activities include the Office of Primary Care and Rural Health's support of Project ECHO Hawaii ( echohawaii.org ), which is an innovative model that utilizes videoconferencing to build primary care workforce capacity while improving patient access to specialty health care in rural communities. FHSD is also partnering with the DOH Developmental Disabilities Division to support a pilot teledentistry program at three early childhood locations in Kona on the Island of Hawaii.

**Priority**: Increase the use of telehealth across Title V activities to improve access to services and education for families and providers.

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

**5-Year Strategies**

Strategies for expansion of telehealth in Title V programs are:

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

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

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

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

**Strategy Development**

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

**State Performance Measure**

The State Performance Measure (SPM) is "The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers." This is a summary of the Data Collection Form that lists 24 strategy components organized by the three areas in telehealth activities:

- Infrastructure development
- Training/education development
- Service development

Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 72. Scoring is completed by FHSD staff. The data collection form is attached as a supporting document.

**Plans for application Year FFY 2017**

The plans for this year will focus on establishing a Title V telehealth work group. Concurrently, the DOH is also convening a telehealth workgroup. The Genomics Section supervisor will represent FHSD on the Department workgroup to assure there is coordination and integration between the groups. More detailed work plans will be developed and funding and staffing identified to assure implementation of the strategies.

Efforts have begun to develop telehealth training curriculum for Title V program staff in conjunction with the University of Hawaii. The plan is to start telehealth training for Title V staff by July 2017. Other objectives include:

- By December 2017, Title V activities are being delivered by telehealth.
- By July 2020, a telehealth network for Title V activities is developed and in use.

By July 2020, coverage for eligible services delivered by Title V programs via telehealth receive maximum reimbursement.

**Priority Need: Family and Consumer Engagement**

Hawaii's Title V program recognizes the importance of family and consumer engagement and strives to honor family partners through formal and informal structures. Title V works closely with the Hilopa'a Family to Family Health Information Center to address family and consumer engagement. In developing the Needs Assessment, priorities were discussed with groups including the Community Children's Councils and Developmental Disabilities Council that included family members. At the 2015 Title V Review, an "ice bucket" challenge was issued to pledge to "collaborate and partner in working to move the needle in Maternal and Child Health, to give all children and their families the best chance to thrive." Part of the challenge was for programs to commit to finding a new family partner. Unfortunately, not many programs used this opportunity to find a new family partner, which led to selecting Family/Consumer Engagement as a State Performance Measure so there would be division-wide support and focus for this effort and a measure that would allow annual reporting to Title V which would help FHSD assess its performance in this area.

There have been various efforts related to family and consumer engagement; however, there is recognition that more could be done to coordinate the effort. Title V staff attended a training on Focus Groups which contained information on working with families and listening to their critical perspective. Challenges to being responsive partners include technical issues of supporting parent stipends for transportation, child care, and time/effort, as well as practical aspects of constructively using information shared by families. In 2015, the FHSD Office of Primary Care and Rural Health (OPCRH) supported the Parent Leadership Training Institute and graduated its first class of parent leaders. However, an infrastructure is needed to support ongoing efforts of parent leaders and partners. Hawaii's Directors of Health and Human Services are working with the ASPEN Institute to study the Two-Generation model and are adopting Ohana Nui ("Extended Family") to approach the generational aspects of engaging with families. Because of the high cost of living and other factors, many Hawaii households are not just two-generation but often grandparents are living with families and extended families; therefore a multi-generational approach is needed. Title

V recognizes the need to also address multi-generations of families and include them as family and consumer partners. By focusing on Family/Consumer Engagement as a State priority, Hawaii will better support families and consumers to effectively use opportunities for improved health outcomes in a changing health care environment.

A theme of family and consumer engagement ran through the five-year needs assessment as each of the priority areas discussed the need for recognizing and supporting family and consumer involvement. Parent and consumer engagement has helped support Title V and other health priorities in various ways, including some of the following examples:

- Family and Consumer Partnerships: Family members are part of many Task Forces and Advisory Councils including the Child Abuse Prevention Planning Council, Fetal Alcohol Spectrum Disorders Task Force, Hawaii Early Intervention Coordinating Council, Newborn Hearing Screening Advisory Committee, Newborn Metabolic Screening Advisory Committee, State Systemic Improvement Plan for Part C, Western States Genetic Services Collaborative.
- Advocacy: Families supported and helped pass the law requiring insurance coverage of medically necessary orthodontic treatment for orofacial anomalies for individuals under age 26 years. Family support of this bill through testimonies at legislative hearings and meetings was critical and many were present at the bill signing by the Governor.
- Strategic and Program Planning: A family leader from the Hilopa'a Family to Family Health Information Center is part of the FHSD leadership team responsible for the Title V needs assessment process, identifying priority issues and performance measures, developing the Title V grant application, and planning for Title V priorities.

**Priority: Family and Consumer Engagement**
The state priority is based on the recognition that there needs to be Division-wide attention and a systemic effort to focus on family and consumer engagement starting with Title V Priorities and permeate through all FHSD programs so that family and consumer engagement is equally valued and prioritized at all levels and services.

**Objective**: By July 2020, increase the engagement of families and consumers in Family Health Services Division activities.

The preliminary 5-year plan objectives were developed by the Title V Planning Team and will be vetted and refined with stakeholders as part of the commitment to family and consumer engagement.

**5-Year Strategies**
Much of the work will focus on three strategic areas: working together on collaboration, providing awareness and education, and encouraging staff development. Ideally the timeline for the five years are as follows:

- Year 1 (2016-17): Staff recognition of State priority focusing on Family/Consumer Engagement and development of activities to support workforce development in this area;
- Year 2 (2017-18): Develop, vet, and implement guidelines for use by all Title V Priority Areas;
- Year 3 (2018-19): Develop, vet, and implement guidelines for use by all FHSD Programs;
- Year 4 (2019-20): Develop, vet, and implement guidelines for use by all DOH Programs.

**Strategy Development**

Strategies were developed based on recommendations from staff and best practices from other states including the Family Voices 2002 "Title V Tip Sheet: Lessons Learned from MCH & CSHCN Directors" on the Benefit of Family Involvement in Title V.

**State Performance Measure**
Percentage of FHSD staff that have increased their knowledge on family/consumer engagement. Current percentage 24% (11/46 rated themselves as experts on this topic, 11/46=.2391, 24%).

Baseline: Number of FHSD Staff who have identified their level of knowledge about the topic of Parent/Family/Consumer Engagement (46 staff): Expert - 23.91% (11 staff), Intermediate – 54.35% (25 staff),

Novice 21.74% (10 staff)

**Plans for Application Year Federal Fiscal Year 2017 (10/1/16-9/30/17)**

In order to respect family and consumer voices as equal partners in the development of the strategies, much of this upcoming year's work will be to engage with Title V staff and family and consumer partners to ensure the development of a plan that meets the needs of all. Most of the 2017 work will revolve around supporting Title V staff's capacity to focus on family and consumer engagement. Hawaii will use the PDSA cycle to find best practices for family/consumer engagement. Some activities include:

- Recognition of State priority focusing on Family/Consumer Engagement;
- Inventory FHSD program efforts in family/consumer engagement by program;
- Set goal for Division (or program)
- Identify target programs that need family/consumer engagement strategy
- Develop strategy
- Link program to family/consumers
- Initiate PDSA Cycle for early adopters to evaluate engagement opportunities and refining processes

**Factors Contributing to Success**

Nationally, Title V has focused on family and consumer engagement. Hawaii reports annually on the involvement of parents and families in FHSD efforts such as through advocacy, serving on task forces or committees, providing feedback and input into planning and program development. In Hawaii, the Directors of Health and Human Services and the Superintendent of the Department of Education have been receiving technical assistance from the ASPEN Institute on the Two-Generation approach which focuses on the importance of family involvement at all levels. With support from Department leadership, Hawaii's Title V Program will be able to exemplify the critical need for a policy or guideline on family and consumer engagement.

**Challenges, Barriers**

There are many systemic challenges in addressing supporting family and consumer engagement. It is envisioned that, working together with families and consumers and state agencies, Hawaii will be able to overcome these barriers.

- Resources: Federal resources are not able to support stipends for parents to attend meetings which incur costs for parents and consumers for transportation, child care, and meeting expenses.
- Staff Capacity: Staff will have to take special consideration into planning meetings to ensure families and consumers can attend including hosting meetings after work-hours or weekends when family and consumers can attend; sending agendas and minutes of past meetings ahead of time and being available to consult with participants to ensure meaningful participation at meetings; arranging for videoconferencing when possible to eliminate the need for families to participate in-person; and finding and supporting a family and consumer representative as appropriate.
- Family/Consumer Burn-out: Oftentimes parents or consumers become token representatives and are asked to attend more than one program meeting. This can become demanding on the family/consumer's time and resources and burn-out is possible unless there is strong support for the representative's attendance and participation at meetings.
- Infrastructure and Policy: As far as we have determined, Hawaii currently has only one program in a state agency that supports families and consumer engagement through stipends and support via the Community Children's Council Office (CCCO) through the Department of Education. Only the Board of Education has a Parent Involvement Policy. Hawaii's Title V and Department of Health needs to examine its role and function to support family and consumer engagement at all levels.

**Plans for Next Year**

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, Hawaii will revise the strategies as needed.

SPM2 – The percentage of Family Health Services Division (FHSD) staff that have increased their knowledge on family/consumer engagement.

**Priority Need: Partner Engagement**

Because of drastic cuts to the State economy in 2009, Hawaii's Department of Health (DOH) suffered a Reduction in Force (RIF) and a reduction in purchase of service dollars. FHSD had 63.75 permanent positions abolished, which resulted in closure of whole units and programs. FHSD is slowly building its workforce again but many staff had to take on additional responsibilities and focus on immediate program needs and priorities as opposed to continuing their partnership efforts. While some FHSD Programs may work with partners and stakeholders, Hawaii needs to identify a systems' approach for how this can be done comprehensively, consistently, and effectively. Not all programs may see themselves as working with partners and may not see the value in exerting efforts to improve relationships that they may not think exist. Title V stresses the importance of partner engagement but leaves it to States to decide how to best achieve this. Hawaii will use this State Performance Measure to plan how to think through this process of meaningful partnership development.

In 2010, a new FHSD Chief, Danette Wong Tomiyasu, was hired and FHSD leadership underwent strategic planning. Through an intensive seven-month process, FHSD determined that its primary audience was not families, but instead was partners, stakeholders, and contractors. FHSD did an environmental scan of its contractors and key partners and determined that partnership is a FHSD strength. In general, FHSD recognizes that it cannot do the work alone and its role as a public health leader is to cultivate, honor, and respect partnerships for improved outcomes for children and families. This led to a revised mission statement, where FHSD is a "progressive leader committed to quality health for the families and communities of Hawaii." FHSD achieves this mission through: quality integrative programs, partner development, operational effectiveness, workforce development. FHSD initially prioritized operational effectiveness and workforce development. In 2015, attention turned towards integration and partnership development. Before becoming good partners to those outside FHSD, a focus was on ensuring colleagues within FHSD recognized the importance of partnership and that the Title V needs assessment was the first step in recognizing that many partners were already working on similar issues and doing their own needs assessments. By selecting Partner Engagement as a State priority, Hawaii will address improving relationships with partners to ensure meaningful outcomes for children and families.

FHSD has learned from many examples that it cannot do this work alone and is dependent on partners (contractors, stakeholders, consultants, etc.) to help support the optimal health and development of Hawaii's people. Evaluation of the partnership work and using evidence-based decision making will only help to improve meaningful engagement with partners.

**Priority: Partner Engagement**

Hawaii's Title V Program has to report on Partnerships, Collaboration and Coordination for its Title V application. Hawaii traditionally reports on partnerships with other DOH agencies, other state agencies, and public-private partnerships. By focusing on partner engagement, FHSD will have the opportunity to examine best practices for meaningful partner engagement and to evaluate how these partnerships can lead to better health outcomes for children and families.

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

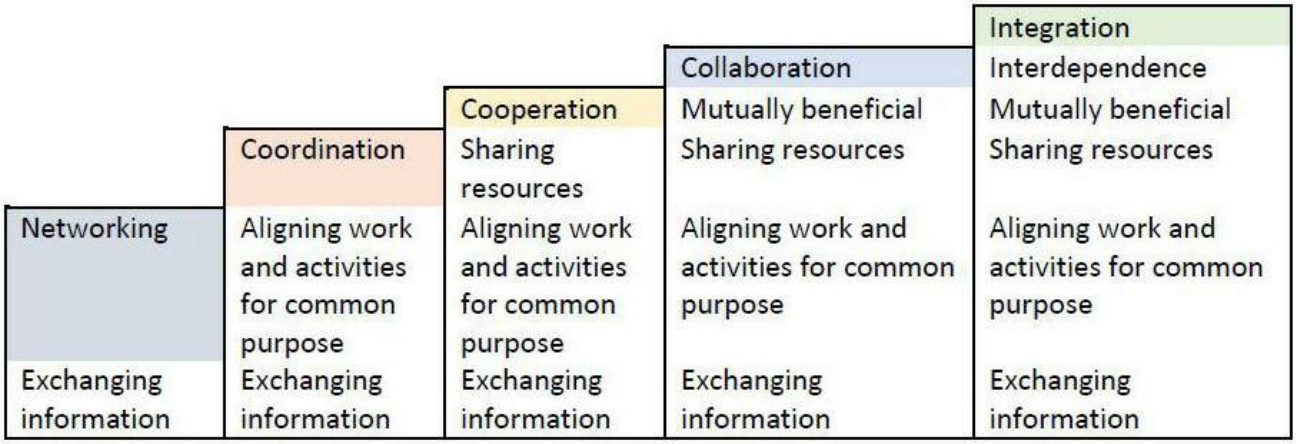
The preliminary 5-year plan objectives were developed by the Title V Planning Team with technical assistance provided by TA providers from the MCHB State Technical Assistance Meeting April 5-6, 2016. Hawaii sent a delegation to the Title V Technical Assistance Working Meeting in April 2016. One of the running themes of the Small-Medium States Group was how to measure partner engagement.

**5-Year Strategies**

Much of the work will focus on three areas: collaboration, education, and staff development. Ideally the timeline for the five years are as follows:

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

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




**Strategy Development**
Strategies were developed based on recommendations from staff and best practices from other states including the MCHB State Technical Assistance Meeting.

**State Performance Measure**
Percentage of FHSD staff that have increased their partner engagement. Current percentage 13% (6/46 rated themselves as experts on this topic).

Baseline: Number of FHSD Staff who have identified their level of knowledge about the topic of Partner Engagement (46 staff): Expert - 13% (6 staff), Intermediate – 58.7% (37 staff), Novice 28.26% (13 staff).

**Plans for Application Year Federal Fiscal Year 2017 (10/1/16-9/30/17)**
Based on the data from the State Performance Measure, there is a large percentage of staff who have intermediate and novice level knowledge on Partner Engagement (87%). Even though Hawaii FHSD staff have heard the prioritization of partner engagement as a State Performance Measure, the Core Team will have to involve the larger workforce in planning this effort since it will have an impact on their workload and capacity. A larger planning team needs to meet to decide on definitions, measures of success, agreement on the Meaningful Partnership Continuum, and evaluation of efforts. Although the focus for the FY 2017 will be on internal FHSD staff development on the topic and look deeper into an Internal Survey Program Self-Assessment, the planning team may need to look at developing Partner Satisfaction Survey. The team will need to decide how to disseminate the survey, how to follow up on results of the survey, and how to implement training of technical assistance as needed.

**Factors Contributing to Success**
Hawaii's Title V Programs will know if it has succeeded in improving meaningful partnerships if the quality of the relationships leads to better-informed decisions and services and improvements to programs and services for children and families. One of the key factors of the success of this endeavor is leadership support as both the Director of Health and the Deputy Director of Health Resources Administration have both shared their vision for the importance of partnerships. The FHSD Core Team, which includes Branch Chiefs, Title V Planner, the CDC Epidemiologist and Neighbor Island FHSD Coordinators, underwent strategic planning and identified partnership as one of the strengths of the division. The Core Team continues to lead the FHSD and supports the focus of partner

engagement which will be the second greatest factor for success.

**Challenges, Barriers**

Taking a critical look at all FHSD programs and services and how they engage with partners will not be easy as Hawaii may find areas of disparity. Because Hawaii is a mix of urban and rural communities and has a multitude of different races and ethnicities, Hawaii needs to work with partners of all different types. Also, because Hawaii is an island-state and remote from the continental states, staff have to depend on each other and partners for services and support. Relationships are essential and yet not all are treated equally for various reasons – geography, service providers in the area, capacity, staff engagement. Taking a critical look at all FHSD programs and services and how they engage with partners will not be easy as Hawaii may find areas of disparities with the number and types of partners that are in the communities. Not all programs may see themselves as working with partners and may not see the value in exerting efforts to improve relationships that they may not think exist. However, in an organization such as FHSD, "partners" come in various forms. Thus the first hurdle that must be addressed is defining partners and supporting all staff to see the value in partnership development. Many programs see themselves as grants managers or executors of contracts and may not see their grantees or contractors as partners. Other challenges may come from staff as well as partners.

Some of the challenges from staff may include:

- Resistance to change;
- Unwillingness to engage;
- Length of the process as this is a five-year commitment and beyond;
- Discomfort at hearing what others may perceive as weakness;
- Inability to recognize constructive criticism as an opportunity for improvement;
- Lack of supervisor support to try new strategies or methods.

Some of the challenges from partners may include:

- Suspicion or distrust of the intent;
- Overcoming previous examples of perceived slights or injuries;
- Lack of a trust or respect;
- History of repeated partner disengagement or disrespect;
- Scarcity of resources or time to engage in the process with FHSD.

**Plans for Next Year**

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, Hawaii will revise the strategies as needed.

**Cross-Cutting/Life Course - Annual Report**

For the Cross-Cutting/Life Course domain Hawaii is reporting on the state performance measure that address the following issue:

- SPM 10: Perinatal/Infant Oral Health

***SPM10: Proportion of children who received dental care in the past year.***

The 2015 Youth Behavioral Risk Survey (YRBS) high school data indicates 70.8% of students reported seeing a dentist in the past year, very similar to the 2013 YRBS data of 70.3%. The 2015 objective was not met, but the Hawaii data was comparable to the national rate of 74.4%. YRBS 2015 middle school dental visitation data also remained largely the same as 2013 (61.5% vs. 61.4%). There is no comparable national middle school data for this measure.

FHSD sponsored the addition of an oral health question in the YRBS after consultation with stakeholders and the MCH Bureau. For high school students in 2015, 29.2% reported having a toothache in the past 12 months compared to 31.4% in 2013. Again the rates remained largely the same with a slight improvement in 2015. The data will be used to help improve the health of adolescents in particular.

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 was one of two areas of care that were identified within the Hawaii State Health Innovation Plan (June 2016) that are especially urgent for Hawaii. Within the Pew Charitable Trusts 50-state reports on oral health, Hawaii has earned an "F" grade in each of the reports published from 2010 to 2015. As a state, Hawaii's keiki are at a huge disadvantage with regard to dental decay due to lacking accessibility to the protective benefit of fluoridated community water systems. Strong public sentiment has persisted over the past fifteen years against efforts to add fluoride to Hawaii's public water systems. The only fluoridated water systems are located on military bases, which accounts for only 11% of community water supplies within the state.

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 developed within the grant were designed to support a "collective impact" approach to oral health improvement. Development of a statewide oral health program continues to be a top strategy in improving oral health and providing better access to care through partnerships across the state.

Some major success has occurred within the oral health program relating to surveillance and reporting of oral health status and barriers to care existing throughout the state. In 2015, a Key Findings summary report was published based upon existing data from self-reported surveys (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.

Also in 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. The survey also included a question regarding whether the child had a dental visit within the last year. However, almost one quarter of participants did not answer the question so results reported are stated to be viewed with caution. In iterations of the BSS, the oral health program hopes to develop a better means to get more complete participation in this question so that it may be more valuable to data reporting. The project completed data collection in May 2015. The sample involved 66 public and charter schools throughout the state on six islands. This was the first year that reported BSS data to the CDC National Oral Health Surveillance System (NOHSS). Hawaii was one of the last five states to provide this data at a national level. The Hawaii Smiles report of this BSS data will be available in 2016. This will prove to be a beneficial data resource across the state for relating the oral health status of children. Plans are underway to conduct a BSS among the Hawaii Head Start students across the state.

In late 2015, FHSD in partnership with the OPPPD, developed an initial plan 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. The HDS Foundation provided grant funding to support the pilot project. Data collection will continue into 2016. One of the goals of the project is to prove the feasibility of a school-based sealant program using a hygienist under general supervision of a dentist and recommending the placement of sealants. This challenges current state practice acts but could result in improvements in access to preventive services to high risk children throughout the state by making school-based

sealant programs financially feasible for community health center dental programs that currently must staff a dentist for these programs.

### Other Programmatic Activities

No content was entered for Other Programmatic Activities in the State Action Plan Narrative section.

### 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 Division Chief position remains vacant as well as the Division Public Health Administrative Officer who oversees fiscal matters for the Division. The Branch Chief position was recently filled in June after having 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.

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.

The new Title V guidance, with its greater emphasis on internal resources, workforce development, and capacity building; are being used to support efforts in the four operational areas. The Title V leadership team used the new grant guidance to explore different ways of working on the needs assessment and block grant report. Dr. Lu's emphasis on people, processes, and products have been overlayed on the core operational issues:

People = Partnership Development and Workforce Development
Processes = Operational Effectiveness
Products = Quality Integrative Programs

In recognition of Dr. Lu's 3 P's mandate, FHSD has begun to identify new ways to transform FHSD's workforce to build capacity and improve effectiveness. One of the first initiatives was to examine how FHSD conducts the Title V grant process. The first *process* that was transformed was the development of the annual Title V report. Normally, the grant is directed from the Division level to the branches and program. Last year, FHSD formally established a working Title V Planning Committee comprised of staff and management from across the Division (including neighbor islands) to direct all Title V activities. The group is facilitated by Leolinda Parlin, the director for the Hilopa`a Family to Family Information Center. Ms. Parlin's participation ensures family perspectives are considered in decisions regarding Title V planning. With the new grant guidance, the Committee has operated as a learning collaborative to understand the opportunities provided by the Title V transformation and direct how Hawaii can best utilize Title V as a resource. The Committee has been critical to transforming the way Title V is done in Hawaii.

The preparation for the 2015 Title V Review exemplified the concepts of FHSD transformation, using data to inform decision-making, and sharing findings from the needs assessment. The Title V Planning Committee developed the Hawaii presentation together, identified staff and key stakeholders to invite. Information and public input materials were shared with all invitees and staff who do not work directly on the annual report. Hawaii has always viewed the annual Title V Review as an opportunity to provide an overview of the Division's programs and resources, priorities, updates, including DOH and the Govenor's Administrative developments. While the presentation is geared for grant reviewers, the Title V Planning Committee helped plan the event to effectively use this opportunity to also inform and *engage* key stakeholders and FHSD staff in Title V. Normally about 50-60 invitees attend the Review each year. Feedback from participants is always very positive. The FHSD PowerPoint presentation prepared for the grant Review is now used as an orientation to new (and existing) FHSD employees. It is often used by staff for presentations to the community and stakeholders.

After the Title V grant review (with minimal changes suggested by the Reviewers), Hawaii was poised to rollout the new priorities with FHSD staff. Instead of a large annual meeting which is usually presented in a conference-format with numerous presentations and short breakouts for staff feedback, the Title V Planning Committee planned a smaller but more intensive opportunity to engage staff and receive feedback on the Title V Strategies. Each of the Priority Leaders were given 15 minutes to share with a small mixed group of FHSD staff about the priorities, receive questions and feedback, and recruit team members. This round-robin session, speed-dating scenario was employed where staff were able to "meet" each of the priorities and to decide of that priority was a good "match" for them.

Because there were 10 issues, each of the Priority Leaders had to share their sessions to 10 different audiences. 10 groups of stakeholders were pre-arranged so there would be equal representation from each of the three branches and Division staff. Information shared and gained from these sessions was informative not just to the Priority Leaders but to people in the group who were able to clarify questions with the Priority Leaders but also with others in their group. Because there are rare opportunities for inter-Branch/Division dialogue, this was an a chance for programs to address concerns with each other and learn about each others' programs. Although it was an exhaustive under-taking (as the Priority Leaders had to repeat their strategies for ten sessions) it was incredibly informative and useful. Each of the participants received a scorecard to identify whether the Priority was a good "match" based on whether the Priority: a) related to their work, b) was of personal interest to them, c) if there were other concerns. Evaluations indicated staff were very engaged by the format & presentations. In addition, the Priority Issue leaders were able to develop, test, and refine their communication skills.

Another innovation was employed to prepare participants for the event. Registration was used an opportunity to survey participants on their interests and knowledge of Title V. A pre-meeting webinar hosted by Ms. Parlin and Title V Planning Committee members, CDC Epidemiologist Dr. Don Hayes and Early Comprehensive Systems Coordinator Ms. Keiko Nitta. The webinar was pre-recorded so participants could view it at their leisure focusing on needs assessment findings and the priority selection. In addition, Dr. Lu's video was also shared. In order to attend the meeting, participants had to view the webinar so they were prepared for the meeting. Moreover, the videos helped reduce the number of presentations at the event and allowed for more time to interact with staff.

The webinar also served as an opportunity for staff to learn how to do a webinar but also demonstrated the

use of this communication tool for their own programs and stakeholders. Participants registered online and were asked questions about their familiarity with the priorities; knowledge of the topics of evidence-based or evidence-informed strategies, partner engagement, and parent/family engagement; and a listing of topics participants were interested in. Some of the topics that participants were most interested in include: using technology and media tools, linking strategies to outcomes, partnership development and maintenance, evaluation design, and evidence based strategies. Very few were interested in public health overview and sources of data repositories. Because the use of technology ranked the highest interest, Ms. Sylvia Mann provided an overview of telehealth at the meeting which is also a State Priority which is being led by Ms. Mann.

The innovative methods utilized in the staff event (i.e. the webinars, registration, and speed-dating format for strategy identification) generated a high level of learning, engagement, excitement (and fun) as indicated in the event evaluations. Staff were able to see their colleagues trying new activities, working differently, (with the encouragement and support by management). More efforts to support changes in MCH people, processes and products are being planned.

Title V staff have been able to take advantage of various MCH and AMCHP opportunities including the MCH Workforce Development Center where Hawaii was part of the first cohort to receive intensive technical assistance (TA) on developmental screening. The use of process maps and continuous quality improvement were tools that the Hawaii team learned and was able to share with the rest of the Title V staff. Hawaii sent a team to the HRSA Title V Technical assistance Working Meeting in April and were able to receive TA but also learn from other states. Hawaii has also utilized TA from Johns Hopkins University Strengthening the Evidence efforts, MCH Bureau Learning labs, as well as national experts. These TA opportunities not only develops staff capacity but also is an opportunity to share Hawaii's issues with other states and national centers.

Hawaii recently was awarded an AMCHP Data Communications and Data Linkages TA grant. Hawaii's Title V Program submitted an application for the Data Communications and Hawaii's Department of Health submitted an application for the Data Linkages. The Data Communications team will learn from communications experts to better communicate and craft our messages to different audiences. Lessons learned from this opportunity will be shared with all staff.

Because of these various opportunities to develop staff capacity, Hawaii plans to create an in-house leadership institute training program to help advance the Title V state priorities. The Leadership Institute 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 AMCHP Data Communications award will be used as part of 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 the Institute. See narrative II.F.7.

Through the development of the training Institute, FHSD intends 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 and other infant/toddler health and safety conferences.
- Hawaii Medicare Rural Hospital Flexibility Program grant is used to conduct training on healthcare quality improvement for healthcare professionals and operational and financial performance improvement for Critical Access Hospitals.

- Family Planning shares resources from the National Family Planning Training Centers to local providers via quarterly meetings, webinars, and conference calls.
- The State Office of Rural Health sponsors numerous training projects such as Community Paramedicine training that utilizes paramedics to provide primary care in rural areas.

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

- Genetics offers webinars on current issues in genetics to providers.
- The Child Abuse and Neglect (CAN) Prevention program conducts presentations on Protective Factors to prevent CAN.
- Primary Care office conducts presentations routinely on loan repayment opportunities to public and private health care/medicine school programs as well as Hawaii Medical Education Council.
- WIC staff conduct breastfeeding training seminars to community providers statewide in partnership with the District Health Offices.
- 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.
- 2015 WIC Statewide Conference
- Early Intervention Stakeholder Conference
- Hawaii Home Visiting Quarterly Meetings
- Hawaii Child Death Review and Maternal Mortality Review Summit

Neighbor Island District Health Offices also sponsor community forums related to emerging concerns, including reducing substance use during pregnancy, Adverse Childhood Experiences (ACE), Fetal Alcohol Spectrum Disorder (FASD). Internally, Children with Special Health Care Needs regularly host speakers at staff meeting on current topics of interest.

**II.F.3. Family Consumer Partnership**

Family/consumer partnerships with FHSD include:

- Title V Block Grant development and review: Ms. Leolinda Parlin, Family Voices/Hawaii Leader and Director of the Hilopaa Family to Family Health Information Center (F2FHIC) is a member of the FHSD leadership team responsible for the Title V needs assessment; identifying and selecting priority issues, performance measures, and strategies; and developing the Title V grant application. Ms. Parlin's participation ensures family perspectives are considered in decisions regarding Title V planning.

- Title V planning for adolescent health: Due to limited staffing/resources for adolescent health, the Adolescent Coordinator partnered with the Hawaii Maternal Child Health Leadership Education in Neurodevelopmental & Related Disabilities (***MCH LEND***) program faculty (Ms. Parlin, also with Hilopaa F2FHIC) to conduct adolescent focus groups and provider surveys to assist with needs assessment activities.

- Title V planning for children with special health care needs: Ms. Parlin is assisting the CSHNB/Children and Youth with Special Health Needs Section (CYSHNS) in launching the work on ESM #12.1 - degree to which the Title V CYSHNS promotes and/or facilitates transition to adult health care for youth with special health care needs age 14-21 years receiving program services. An all-day planning meeting in July 2016 is scheduled.

- Advisory committees: Family leaders/partners of diverse ethnicities participate on various councils, committees, and collaboratives related to FHSD programs including:
    - Child Abuse Prevention Planning Council
    - Fetal Alcohol Spectrum Disorders Task Force
    - Hawaii Early Intervention Coordinating Council
    - Newborn Hearing Screening Advisory Committee
    - Newborn Metabolic Screening Advisory Committee
    - State Systemic Improvement Plan for Part C
    - Western States Genetic Services Collaborative

- Quality improvement: In 2014, the CSHNB/CYSHNS participated in the ABCs of Quality Improvement sponsored by the National Center for Family Professional Partnerships. The team worked on a quality improvement project related to the transition of youth with special health care needs to adult life. Team members included a family member from the Hilopaa F2FHIC.

- Materials development: The revision of the brochure for the CSHNB/Early Intervention Section included review and input from family members of children age 0-3 years with developmental delay or at biological risk for developmental delay receiving early intervention services.

- Legislative advocacy:
    - After a three year effort, House Bill 174 (Act 213) became law in July 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. Families supported this bill through testimonies at legislative hearings and meetings. Title V staff, Hilopaa F2FHIC, and 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.
    - Senate Bill 2476 (Act 177) became law in June 2016, with many families present at the bill signing by the Governor. The law establishes a working group for the purpose of making recommendations to the legislature on issues related to supporting age-appropriate language development for children age 0-5 years who are deaf, hard of hearing, or deaf-blind. The bill was passed by the legislature due to strong support from consumers and families. DOH/CSHNB worked with the Department of Education, Executive Office on Early Learning, and community/family advocates on proposed language for this bill.

To support family partnership/leadership development, the FHSD Office of Primary Care and Rural Health 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. 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.

Title V staff attended a training on Focus Groups which contained information on working with families and their

critical perspective. Challenges to being responsive partners include technical issues of supporting parent stipends for transportation, child care, and time/effort, as well as practical aspects of constructively using information shared by families.

Hawaii's Directors of Health and Human Services are working with the ASPEN Institute to study the Two-Generation model and are adopting Ohana Nui ("Extended Family") to approach the generational aspects of engaging with families. Title V recognizes the need to also address multi-generations of families and include them as parent partners.

Family and consumer engagement was a theme throughout the five-year Title V needs assessment as each priority area discussed the need to recognize and support family and consumer involvement. At the 2015 Title V Review, an "ice bucket" challenge was issued to pledge to "collaborate and partner in working to move the needle in Maternal and Child Health, to give all children and their families the best chance to thrive." Part of the challenge was for programs to commit to finding a new family partner.

To better support parent partners to effectively use opportunities in a changing health care environment, FHSD in 2016 added a state priority on family and consumer engagement in Title V programs, and a State Performance Measure on increasing the engagement of families and consumers in FHSD activities. The state priority recognizes that there needs to be Division-wide attention and a systemic effort to focus on family and consumer engagement starting with Title V Priorities and spreading through all FHSD programs. Much of this upcoming year's work will be to engage with Title V staff and family and consumer partners to ensure a plan that meets the needs of all, and to support Title V staff's capacity to focus on family and consumer engagement.

### 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.

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. Hawaii was also not able to integrate Medicaid enrollment into the Connector, another federal requirement for state exchanges. All enrollment for ACA coverage is now through HealthCare.gov.

Hawaii data (from the US Department of Health and Human Services) on enrollment through HealthCare.gov for the period 11/1/15 to 2/1/16 showed:

- 17,517 individuals were eligible to enroll in a Marketplace plan.
- 13,885 individuals were eligible to enroll in a Marketplace plan with financial assistance.
- 7,119 individuals were determined eligible for Medicaid.
- 14,564 individuals selected a Marketplace plan.

### II.F.5. Emerging Issues

**ZIKA VIRUS INFECTION**

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

Current DOH response protocols/activities:

- Report of a suspect case triggers a case investigation by the Disease Outbreak and Control Division (DOCD)/Disease Investigation Branch and a request for Vector Control to assess the case residence. DOCD aggressively investigates all reported cases of Zika to reduce the possibility of the disease spreading in Hawaii.
- Zika testing is performed at the State Laboratories Division. Further antibody testing is performed at the CDC.
- Once confirmed, cases are reported to CDC's ArboNET.
- DOCD is the lead for the U.S. Zika Pregnancy Registry efforts. DOCD gathers and provides information (without identifiers) to the U.S. Zika Pregnancy Registry. States have been asked to monitor Zika-infected pregnant women through their pregnancy and their infants through the first year of life.
- Medical advisories to health care providers have included clinical updates, clinician guidance on testing and

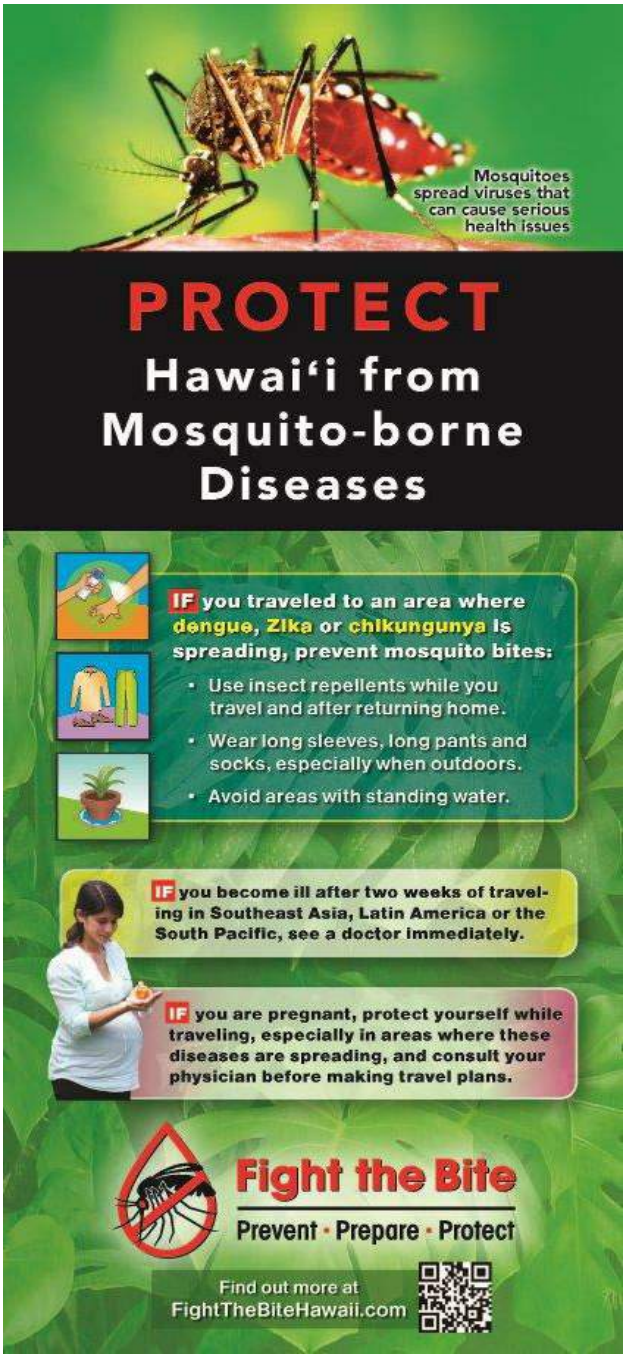
patient care and counseling, and testing for Zika virus.

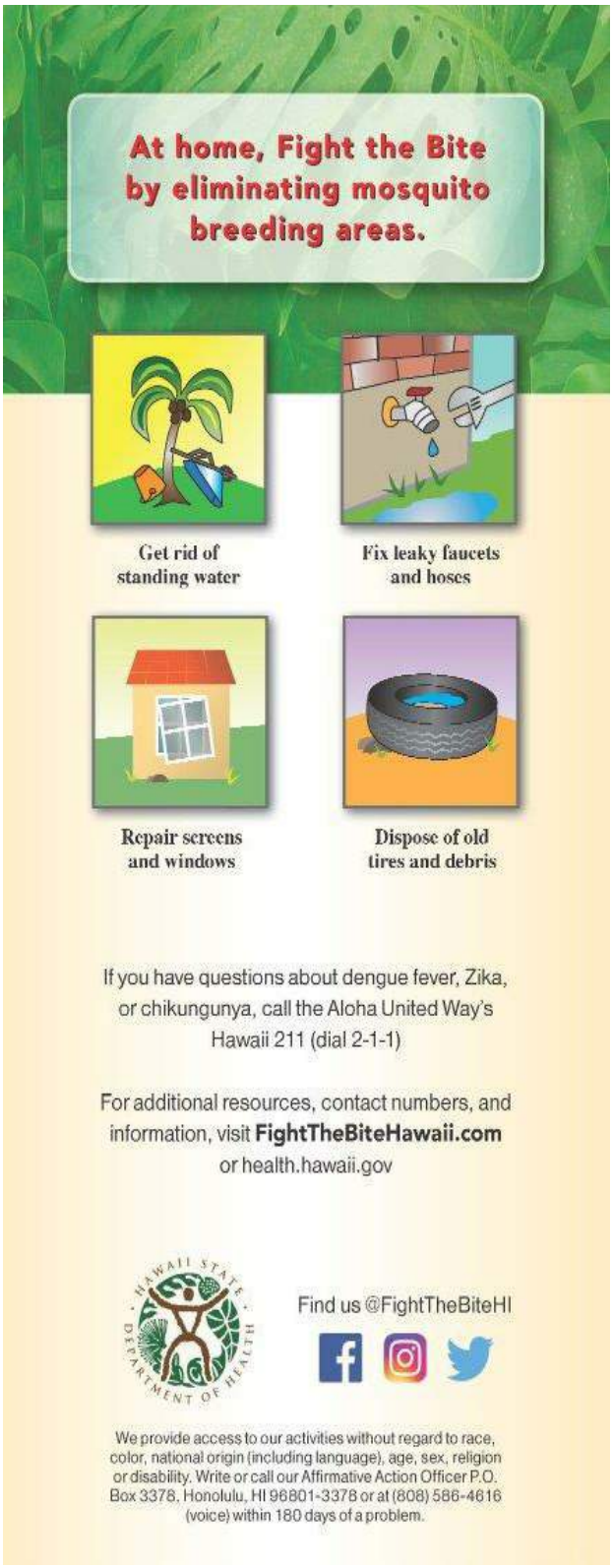
DOCD is the lead for the Hawaii DOH Zika Virus Coordinating Team, which includes representation from the Family Health Services Division (FHSD), State Laboratory Division, Communicable Disease and Public Health Nursing Division, Harm Reduction Services Branch (Sexually Transmitted Disease Prevention and Education Programs), state epidemiologists from various divisions, and the DOH Communications Office. The DOH collaborative effort is working to address identification of cases, prevention, education, surveillance, timely data collection, information dissemination, and coordination of efforts around the possible risks for adverse outcomes associated with Zika virus infection.

FHSD coordination and activities:

- Genomics Section is the lead in coordinating Zika activities within FHSD. Pertinent FHSD programs include the CSHNB/Genomics Section (Hawaii Birth Defects Program, Newborn Metabolic Screening Program, Newborn Hearing Screening Program, Genetics Program), Children and Youth with Special Health Needs Section, and Early Intervention Section; Maternal and Child Health Branch (Family Planning, Perinatal Support Services, Home Visiting); WIC Services Branch; and Family Health Services offices within the District Health Offices for Hawaii, Maui, and Kauai counties. Areas for FHSD coordination include:
    - Input to the Communications Office on draft materials for the media campaign, and getting updates on the Zika media campaign.
    - Collaboration with DOCD/Communications Office on developing materials for family planning and pregnant women.
    - Dissemination of Zika informational materials.
    - Coordinating FHSD program websites (MCHB/WIC/CSHNB) so that they are linked to the DOCD Zika website (http://health.hawaii.gov/docd/dib/disease/zika_virus/) and have consistent messaging and current information.
- In January 2016, Hawaii Birth Defects Program (HBDP) began work with the state birthing facilities to implement “real time” (at least weekly) reporting of babies born with microcephaly or other central nervous system defects. HBDP is also participating in abstracting information for the U.S. Zika Pregnancy Registry with DOCD.
- Early Intervention Section (EIS) provides early intervention services for children with microcephaly related to Zika. DOCD was recently consulted on the EIS staff use of protective measures (gloves, mask, gown) when they do home visits.
- Genomics Section has applied for a CDC grant on surveillance, intervention, and referral for infants with microcephaly or other adverse outcomes linked with the Zika virus. Funding and technical assistance will enable the HBDP to engage in surveillance, collaboration, and data utilization activities to improve the quality and timeliness of data collection to address the impact of Zika virus infection and possible adverse birth outcomes; increase the ability for effective and timely analysis and dissemination of the data; and link providers and families with or at risk for birth defects to available resources and services.

The statewide multi-media campaign launched on 6/30/2016. The campaign includes television commercial spots, radio advertisements including ethnic media, mall/shopping center advertisements, airport banners, general brochure about mosquito borne diseases, Fight the Bite rack card about protecting Hawaii from mosquito-borne diseases, Fight the Bite website http://fightthebitehawaii.com/, bus placards, infographics, community outreach, educator and school/community toolkits, and social media.


Mosquitoes spread viruses that can cause serious health issues
PROTECT
Hawai'i from Mosquito-borne Diseases
IF you traveled to an area where dengue, Zika or chikungunya is spreading, prevent mosquito bites:
• Use insect repellents while you travel and after returning home.
• Wear long sleeves, long pants and socks, especially when outdoors.
• Avoid areas with standing water.
IF you become ill after two weeks of traveling in Southeast Asia, Latin America or the South Pacific, see a doctor immediately.
IF you are pregnant, protect yourself while traveling, especially in areas where these diseases are spreading, and consult your physician before making travel plans.
Fight the Bite
Prevent · Prepare · Protect
Find out more at FightTheBiteHawaii.com




### II.F.6. Public Input

Materials were developed for sharing with stakeholders and to collect public input (see Supporting

Documents). These included:

- Title V Quick Fact Sheet, with information about FHSD and Title V, including the Hawaii Title V priorities and strategies, and information/data on the priorities.
- Online survey at https://www.surveymonkey.com/r/2016TitleV-Hawaii. The survey asks: Will FHSD's work on these priorities and strategies help to improve the health of families in Hawaii? What are other strategies that FHSD should consider?

FHSD staff presented information at various meetings, including the Community Children's Council Co-Chair meeting with parent and professional co-chairs from all islands, and Healthy Child Care Hawaii.

FHSD's website on Title V Maternal & Child Health Block Grant was updated to include the Title V Quick Fact Sheet and online survey (http://health.hawaii.gov/fhsd/title-v-maternal-child-health-block-grant/). 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

Feedback/comments obtained at in-person meetings and by survey included:

- **FHSD's work to improve the health of families in Hawaii:** This requires engagement and partnership of POS private agencies and POS agencies to move the needle.
- **Promote reproductive life planning:** Engage men and boys in the conversation. Develop a public awareness campaign to inform the community what does reproductive life planning look like and its importance in overall well-being of the mother and her unborn child.
- **Promote breastfeeding:** Provide education to businesses to support mothers to breastfeed. Expand the Breastfeeding Peer Counseling Program in the neighbor islands.
- **Promote safe sleep:** Education through storytelling of unsafe sleep situations. Develop a public awareness campaign on safe sleep environment for infants.
- **Prevent child abuse and neglect:** Provide opportunities for free family outings, especially those with young children. Hospitals should distribute info regarding strong emotional attachments with children. Promote the use of the 5 protective factors in home visiting programs and early intervention services.
- **Promote developmental screenings and services:** Public Service Announcements. Form a formal agreement or MOU with DHS EPSDT program and all agencies that are doing child developmental screening and monitoring.
- **Promote adolescent well-being:** Provide "cool" public awareness posters & website links to local teen resources to pediatricians. Form an agreement or MOU with all adolescent servicing agencies within DOH and DHS.
- **Promote transition to adult health care:** Review and evaluate the CSHNP Transition Plan Guidelines for effectiveness.
- **Improve oral health:** Need PSA about how often to brush; dental health in Hawaii is terrible. Promote oral health wellness guidelines for all ages.
- **Improve access to services through telehealth:** Expand existing telehealth services in the state.
- **Engage families and consumers as partners with FHSD:** Expand existing policy councils within FHSD programs to ensure that there are parents and the general community members to inform and guide the work and programs of FHSD. Consider the DOE's model of Leading by Convening.
- **Increase meaningful partnerships with FHSD:** Meet more often with potential partners and include them in strategic planning. Create MOUs and formal partnerships within DOH, our POS agencies, DHS and their POS agencies that encounter the population that FHSD serves.

A report of the survey results will be presented at the Title V Review meeting in Honolulu on 8/15/16. Public input comments will be considered in Title V planning. Title V will use the input to guide planning and development of activities over the next year. Several comments to date have focused on the need to improve communications and health messaging. The comments will also help inform the initiatives FHSD develops using the AMCHP

Communications Technical Assistance award received this summer.

### II.F.7. Technical Assistance

Title V staff have taken advantage of various MCH Bureau and Association of Maternal and Child Health Programs (AMCHP) technical assistance (TA) opportunities. These opportunities not only develop staff capacity but also provide an opportunity to share Hawaii issues with other states and national centers. TA has included:

- MCH Workforce Development Center: Hawaii was part of the first cohort to receive intensive TA on developmental screening. The Hawaii team learned the use of process maps and continuous quality improvement and shared these tools with other Title V staff.
- HRSA Title V TA Working Meeting (April 2016): A Hawaii team received TA and also had the opportunity to learn from other states.
- Developing Title V evidence-based/-informed strategy measures: In 2016, Hawaii utilized TA from Johns Hopkins University Strengthen the Evidence Base for MCH Programs, Got Transition, and MCH Bureau Learning Labs.
- AMCHP Data Translation: MCH Data Communications Partnerships TA project (May to December 2016) will help the Hawaii Title V team learn from communications experts to better communicate and craft messages to different audiences. Lessons learned from this opportunity will be shared with all staff.
- AMCHP Data Linkage: Phase I–MCH and Medicaid Data Partnerships TA project (May 2016 to October 2017) is helping a DOH team to research contraceptive use (e.g., Long Acting Reversible Contraception) and inter-pregnancy intervals.

As noted in Subsection II.F.2. MCH Workforce Development, Title V will submit a TA request to support piloting a Leadership Training Institute for program staff. Because of the various opportunities to develop staff capacity, Hawaii plans to create an in-house leadership institute training program to help advance the Title V state priorities. The Leadership Institute 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. Training resources will help to inform the development and monitoring of the Title V 5-year plan strategies and activities. The program will assure integration and application of science-based practices, quality improvement techniques, and systems approaches to effectively improve health outcomes.

An additional TA request for a Title V overview presentation by the federal MCH Bureau is included in this report as a suggestion for Hawaii's August 15, 2016 grant review meeting. Hawaii greatly appreciated last year's Title V overview presentation by MCH Bureau staff, and would like to request a similar 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. Because the Title V annual report is developed with contributions from numerous staff and agency partners, approximately 40 to 60 participants are invited to attend the federal grant review, including external partners and neighbor island staff who fly into Honolulu. An overview will provide essential background/orientation information to help staff and partners understand MCH as a field in public health and 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.

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 that participants have a clear understanding of the purpose for the section and to help FHSD improve reporting next year.

### III. Budget Narrative

| | 2013 | | 2014 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| **Federal Allocation** | $2,229,698 | $1,729,375 | $2,024,653 | $1,486,740 |
| **Unobligated Balance** | $93,332 | $435,963 | $0 | $332,197 |
| **State Funds** | $23,785,948 | $23,369,691 | $25,296,742 | $23,049,391 |
| **Local Funds** | $0 | $0 | $0 | $0 |
| **Other Funds** | $75,000 | $69,555 | $75,000 | $13,760 |
| **Program Funds** | $11,043,354 | $9,579,148 | $19,135,183 | $9,924,594 |
| **SubTotal** | $37,227,332 | $35,183,732 | $46,531,578 | $34,806,682 |
| **Other Federal Funds** | $45,736,612 | $45,650,832 | $47,260,340 | |
| **Total** | $82,963,944 | $80,834,564 | $93,791,918 | $34,806,682 |

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.

| | 2015 | | 2016 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| **Federal Allocation** | $2,144,047 | $1,390,506 | $2,156,997 | |
| **Unobligated Balance** | $228,563 | $670,258 | $422,453 | |
| **State Funds** | $25,217,539 | $22,376,536 | $28,911,631 | |
| **Local Funds** | $0 | $0 | $0 | |
| **Other Funds** | $75,000 | $6,359 | $75,000 | |
| **Program Funds** | $19,172,085 | $11,342,262 | $16,520,311 | |
| **SubTotal** | $46,837,234 | $35,785,921 | $48,086,392 | |
| **Other Federal Funds** | $45,034,232 | $0 | $54,186,151 | |
| **Total** | $91,871,466 | $35,785,921 | $102,272,543 | |

| | 2017 | |
|---|---|---|
| | Budgeted | Expended |
| **Federal Allocation** | $2,176,627 | |
| **Unobligated Balance** | $651,223 | |
| **State Funds** | $29,083,184 | |
| **Local Funds** | $0 | |
| **Other Funds** | $75,000 | |
| **Program Funds** | $16,745,817 | |
| **SubTotal** | $48,731,851 | |
| **Other Federal Funds** | $55,420,856 | |
| **Total** | $104,152,707 | |

### III.A. Expenditures

**Significant Budget Variations – Form 2 (Fiscal Year 2015)**

Item 1. Federal Allocation. The estimated award for the fiscal year 2015 Title V Block Grant application was $2,144,047, however the actual amount expended for the amount awarded in fiscal year 2015 was $1,390,506. The variance is due to the $670,258 in unobligated Title V funds carried over into fiscal year 2015 from the fiscal year 2014 grant award.

> Item 1A. Earmark for Preventive and Primary Care for Children. The amount budgeted in this category for fiscal year 2015 was $876,915, however the amount actually expended was $585,267, a difference of $291,648. 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 2015.
>
> Item 1B. Earmark for Children with Special Health Care Needs. Of the $724,045 budgeted in fiscal year 2015 for this category, a sum of $435,918 was actually expended. As mentioned above, the Family Health Services Division did not fill vacant Title V funded positions to ensure that there were sufficient grant funds to meet salary, fringe benefit, and operating costs.
>
> Item 1C. Title V Administrative Cost. The budgeted amount for this category in fiscal year 2015 is $186,318, and the actual amount expended from the fiscal year 2015 was $60,378, a difference of $125,940. This difference is due to $114,078 being expended from the fiscal year 2014 Title V award in federal fiscal year 2015 for administrative costs.

Item 2. Unobligated Balance. The actual expenditures of $670,258 for the category "Unobligated Balance" was higher than the budgeted amount of $228,563 in fiscal year 2015 due to unfilled vacant Title V funded positions. Although Hawaii reflects an unobligated balance of $670,258 at the end of federal fiscal year 2015, these funds were

fully utilized to pay for infrastructure positions for FHSD commencing in federal fiscal year 2016; thus, the Family Health Services Division did not fill vacant Title V funded positions to ensure that there were sufficient grant funds to meet salary, fringe benefit and operating costs.

Item 3. State Funds. The amount budgeted for the category "State Funds" was $25,217,539 in fiscal year 2015, and the amount actually expended was $22,376,536, a difference of $2,841,003. This difference is attributed to outstanding unliquidated encumbrances as of September 30, 2015.

Item 5. Other Funds. The budgeted amount for the category "Other Funds" was $75,000 in fiscal year 2015, and the actual expenditures amounted to $6,359, a decrease of $68,641. 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 2015 was $19,172,085, and the amount actually expended was $11,342,262. The reason for the difference is that the authorized budget ceilings for the Community Health Centers Special Fund, Early Intervention Special Fund, and the Domestic Violence and Sexual Assault Special Fund is higher than the revenues being deposited into these accounts. Accordingly, the funds being expended annually is congruent with the revenues being deposited, and not with the authorized budget ceilings for these special fund accounts.

**III.B. Budget**

The State's maintenance of effort level from 1989 is $11,910,549 and the State's overmatch in fiscal year 2017 is $17,172,635. There are no continuation funding for special projects, or for special consolidated projects in fiscal year 2017.

**Significant Budget Variations – Form 2 (Fiscal Year 2017)**

Item 1. Federal Allocation. The "Federal Allocation" category for fiscal year 2017 amounts to $2,176,627. The Federal Allocation amount being used for the fiscal year 2017 Title V grant application is the same as the estimated Title V grant award for fiscal year 2016.

Item 1. A-C. Earmarks for Preventive and Primary Care for Children, Children with Special Health Needs, and Administrative Costs.

Item 1A. Preventive and Primary Care for Children. The amount budgeted for this category in the fiscal year 2016 grant application was $737,477, and the amount budgeted for this category in the fiscal year 2017 application is $778,528. This does not reflect a significant variation.

Item 1B. Children with Special Health Care Needs. The amount budgeted for this category in the fiscal year 2016 application was $938,725, and the amount budgeted for this category in the fiscal year 2017 application is $761,805. The decrease of $176,920 is due to recent Title V funded position vacancies in the Children with Special Health Care Needs Branch.

Item 1C. Title V Administrative Costs. The amount budgeted for this category in the fiscal year 2016 application was $115,511, and the amount budgeted for this category in the fiscal year 2017 application is $191,301. The increase of $75,790 is due to collective bargaining and fringe benefit rate increases.

Item 2. Unobligated Balance. The estimated unobligated balance from the fiscal year 2016 grant application was $422,453, and the estimated unobligated balance in fiscal year 2017 is $651,223. The increase in the estimated unobligated balance for fiscal year 2017 is due to the continuing implementation of cost savings measures. For example, vacant Title V funded positions are being left unfilled to ensure that there are sufficient grant funds to meet increases in collective bargaining and fringe benefit costs in fiscal year 2017. Collective bargaining and fringe benefit costs continue to escalate each year, however the Title V grant awards have remained at relatively the same levels in recent years.

Item 3. State MCH Funds. The category “State MCH Funds” has increased slightly from $28,911,631 in fiscal year 2016 to $29,083,184 in fiscal year 2017. This does not represent a significant variation.

Item 6. Program Income. The category “Program Income” has slightly increased from $16,520,311 in fiscal year 2016 to $16,745,817 in fiscal year 2017. This does not represent a significant variation.

Item 9. Other Federal Funds. The category “Other Federal Funds” has increased slightly from $54,186,151 in fiscal year 2016 to $55,420,856 in fiscal year 2017. This does not represent a significant variation.

**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 - ESM Data Collection Forms.pdf

Supporting Document #02 - SPM 1 Telehealth Data Collection Forms.pdf

Supporting Document #03 - Title V Quick Fact Sheet.pdf

Supporting Document #04 - GLOSSARY OF TERMS.pdf

## VI. Appendix

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**Form 2**

**MCH Budget/Expenditure Details**

**State: Hawaii**

| | FY17 Application Budgeted | |
|---|---|---|
| 1. FEDERAL ALLOCATION<br>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | $ 2,176,627 | |
| A. Preventive and Primary Care for Children | $ 778,528 | (35.8%) |
| B. Children with Special Health Care Needs | $ 761,805 | (35%) |
| C. Title V Administrative Costs | $ 191,301 | (8.8%) |
| 2. UNOBLIGATED BALANCE<br>(Item 18b of SF-424) | $ 651,223 | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 29,083,184 | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 0 | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 75,000 | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 16,745,817 | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 45,904,001 | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 11,910,549 | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Same as item 18g of SF-424) | $ 48,731,851 | |
| 9. OTHER FEDERAL FUNDS<br>Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2. | | |
| 10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9) | $ 55,420,856 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 104,152,707 | |

| OTHER FEDERAL FUNDS | FY17 Application Budgeted |
|---|---|
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Program (CBCAP) | $ 454,196 |
| US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC) | $ 34,210,089 |
| 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) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration | $ 426,600 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS) | $ 161,000 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program | $ 255,086 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant | $ 40,000 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program | $ 250,000 |
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program | $ 196,772 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI) | $ 100,000 |
| US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA) | $ 2,247,675 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program | $ 12,969,228 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention | $ 250,000 |
| 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) > Office of Population Affairs (OPA) > Title X Family Planning | $ 2,157,300 |

| OTHER FEDERAL FUNDS | FY17 Application Budgeted |
|---|---|
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Health | $ 172,000 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO) | $ 167,994 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Medicare Rural Hospital Flexibility Program | $ 419,316 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospital Improvement Program | $ 93,600 |

| | FY15 Application Budgeted | | FY15 Annual Report Expended | |
|---|---|---|---|---|
| 1. FEDERAL ALLOCATION<br>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | $ 2,144,047 | | $ 1,390,506 | |
| A. Preventive and Primary Care for Children | $ 876,915 | (40.9%) | $ 585,267 | (42.1%) |
| B. Children with Special Health Care Needs | $ 724,045 | (33.8%) | $ 435,918 | (31.3%) |
| C. Title V Administrative Costs | $ 186,318 | (8.7%) | $ 60,378 | (4.3%) |
| 2. UNOBLIGATED BALANCE<br>(Item 18b of SF-424) | $ 228,563 | | $ 670,258 | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 25,217,539 | | $ 22,376,536 | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 0 | | $ 0 | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 75,000 | | $ 6,359 | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 19,172,085 | | $ 11,342,262 | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 44,464,624 | | $ 33,725,157 | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 11,910,549 | | | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Same as item 18g of SF-424) | $ 46,837,234 | | $ 35,785,921 | |
| 9. OTHER FEDERAL FUNDS<br>Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2. | | | | |
| 10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9) | $ 45,034,232 | | $ 0 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 91,871,466 | | $ 35,785,921 | |

| OTHER FEDERAL FUNDS | FY15 Annual Report Expended |
| --- | --- |
| No Other Federal Programs were provided by the State on Form 2 Line 9. | |

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Federal Allocation, C. Title V Administrative Costs** |
| | **Fiscal Year:** | **2017** |
| | **Column Name:** | **Application Budgeted** |
| | **Field Note:**<br>$191,301 part of 1A and 1B | |
| 2. | **Field Name:** | **2. UNOBLIGATED BALANCE** |
| | **Fiscal Year:** | **2017** |
| | **Column Name:** | **Application Budgeted** |
| | **Field Note:**<br>Although Hawaii reflects an unobligated balance of $670,258 at the end of federal fiscal year 2015, these funds were fully utilized to pay for infrastructure positions for FHSD commencing in federal fiscal year 2016. | |
| 3. | **Field Name:** | **Federal Allocation, A. Preventive and Primary Care for Children:** |
| | **Fiscal Year:** | **2015** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>The amount budgeted in this category for fiscal year 2015 was $876,915, however the amount actually expended was $585,267, a difference of $291,648. 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 2015. | |
| 4. | **Field Name:** | **Federal Allocation, B. Children with Special Health Care Needs:** |
| | **Fiscal Year:** | **2015** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>Of the $724,045 budgeted in fiscal year 2015 for this category, a sum of $435,918 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. | |
| 5. | **Field Name:** | **Federal Allocation, C. Title V Administrative Costs:** |
| | **Fiscal Year:** | **2015** |
| | **Column Name:** | **Annual Report Expended** |

| | | |
|---|---|---|
| | **Field Note:**<br>The budgeted amount for this category in fiscal year 2015 is $186,318, and the actual amount expended from the fiscal year 2015 was $60,378, a difference of $125,940. This difference is due to $114,078 being expended from the fiscal year 2014 Title V award in federal fiscal year 2015 for administrative costs. | |
| 6. | **Field Name:** | **2. UNOBLIGATED BALANCE** |
| | **Fiscal Year:** | **2015** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>The actual expenditures of $670,258 for the category “Unobligated Balance” was higher than the budgeted amount of $228,563 in fiscal year 2015 due to unfilled vacant Title V funded positions. As mentioned previously, the Family Health Services Division did not fill vacant Title V funded positions to ensure that there were sufficient grant funds to meet salary, fringe benefit and operating costs. | |
| 7. | **Field Name:** | **3. STATE MCH FUNDS** |
| | **Fiscal Year:** | **2015** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>The amount budgeted for the category “State Funds” was $25,217,539 in fiscal year 2015, and the amount actually expended was $22,376,536, a difference of $2,841,003. This difference is attributed to outstanding unliquidated encumbrances as of September 30, 2015. | |
| 8. | **Field Name:** | **5. OTHER FUNDS** |
| | **Fiscal Year:** | **2015** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>The budgeted amount for the category “Other Funds” was $75,000 in fiscal year 2015, and the actual expenditures amounted to $6,359, a decrease of $68,641. 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. | |
| 9. | **Field Name:** | **6. PROGRAM INCOME** |
| | **Fiscal Year:** | **2015** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>The amount budgeted for this category in fiscal year 2015 was $19,172,085, and the amount actually expended was $11,342,262. The reason for the difference is that the authorized budget ceilings for the Community Health Centers Special Fund, Early Intervention Special Fund, and the Domestic Violence and Sexual Assault Special Fund is higher than the revenues being deposited into these accounts. Accordingly, the funds being expended annually is congruent with the revenues being deposited, and not with the authorized budget ceilings for these special fund accounts. | |

| | | |
|---|---|---|
| 10. | **Field Name:** | **1.FEDERAL ALLOCATION** |
| | **Fiscal Year:** | **2015** |
| | **Column Name:** | **Annual Report Expended** |

**Field Note:**
The estimated award for the fiscal year 2015 Title V Block Grant application was $2,144,047, however the actual amount expended for the amount awarded in fiscal year 2015 was $1,390,506. The variance is due to the $670,258 in unobligated Title V funds carried over into fiscal year 2015 from the fiscal year 2014 grant award.

**Data Alerts: None**

**Form 3a**

**Budget and Expenditure Details by Types of Individuals Served**

**State: Hawaii**

## I. TYPES OF INDIVIDUALS SERVED

| IA. Federal MCH Block Grant | FY17 Application Budgeted | FY15 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 401,817 | $ 266,905 |
| 2. Infants < 1 year | $ 43,176 | $ 42,038 |
| 3. Children 1-22 years | $ 778,528 | $ 585,267 |
| 4. CSHCN | $ 761,805 | $ 435,918 |
| 5. All Others | $ 0 | $ 0 |
| Federal Total of Individuals Served | $ 1,985,326 | $ 1,330,128 |

| IB. Non Federal MCH Block Grant | FY17 Application Budgeted | FY15 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 4,644,017 | $ 1,966,021 |
| 2. Infants < 1 year | $ 4,168,557 | $ 3,123,234 |
| 3. Children 1-22 years | $ 9,673,995 | $ 6,178,832 |
| 4. CSHCN | $ 20,278,479 | $ 17,295,940 |
| 5. All Others | $ 7,138,953 | $ 5,161,130 |
| Non Federal Total of Individuals Served | $ 45,904,001 | $ 33,725,157 |
| Federal State MCH Block Grant Partnership Total | $ 47,889,327 | $ 35,055,285 |

**Form Notes for Form 3a:**

None

**Field Level Notes for Form 3a:**

None

**Data Alerts: None**

**Form 3b**
**Budget and Expenditure Details by Types of Services**

**State: Hawaii**

**II. TYPES OF SERVICES**

| IIA. Federal MCH Block Grant | FY17 Application Budgeted | FY15 Annual Report Expended |
|---|---|---|
| 1. Direct Services | $ 0 | $ 0 |
| A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One | $ 0 | $ 0 |
| B. Preventive and Primary Care Services for Children | $ 0 | $ 0 |
| C. Services for CSHCN | $ 0 | $ 0 |
| 2. Enabling Services | $ 403,003 | $ 177,955 |
| 3. Public Health Services and Systems | $ 1,773,624 | $ 1,212,551 |
| 4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service | | |
| Pharmacy | | $ 0 |
| Physician/Office Services | | $ 0 |
| Hospital Charges (Includes Inpatient and Outpatient Services) | | $ 0 |
| Dental Care (Does Not Include Orthodontic Services) | | $ 0 |
| Durable Medical Equipment and Supplies | | $ 0 |
| Laboratory Services | | $ 0 |
| Direct Services Line 4 Expended Total | | $ 0 |
| **Federal Total** | $ 2,176,627 | $ 1,390,506 |

| IIB. Non-Federal MCH Block Grant | FY17 Application Budgeted | FY15 Annual Report Expended |
|---|---|---|
| 1. Direct Services | $ 18,872,512 | $ 13,549,925 |
| A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One | $ 2,796,194 | $ 779,128 |
| B. Preventive and Primary Care Services for Children | $ 5,523,969 | $ 3,195,498 |
| C. Services for CSHCN | $ 10,552,349 | $ 9,575,299 |
| 2. Enabling Services | $ 11,532,045 | $ 9,031,257 |
| 3. Public Health Services and Systems | $ 9,499,782 | $ 6,635,643 |
| 4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service | | |
| Pharmacy | | $ 0 |
| Physician/Office Services | | $ 1,707,615 |
| Hospital Charges (Includes Inpatient and Outpatient Services) | | $ 0 |
| Dental Care (Does Not Include Orthodontic Services) | | $ 1,254,285 |
| Durable Medical Equipment and Supplies | | $ 0 |
| Laboratory Services | | $ 0 |
| Other | | |
| Primary and Urgent Care in Hana | | $ 375,152 |
| Waianae Coast Emergency Rooms Services | | $ 375,152 |
| Early Intervention Services (POS) | | $ 9,837,721 |
| Direct Services Line 4 Expended Total | | $ 13,549,925 |
| **Non-Federal Total** | $ 39,904,339 | $ 29,216,825 |

**Form Notes for Form 3b:**

It should be noted that Form 3b does not include a category for “All Others” under Direct Services. Accordingly, the budget for fiscal year 2017 and the expenditures for fiscal year 2015 does not provide a complete snapshot of all direct services provided by the Family Health Services Division.

**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: 18,444**

**1. Core RUSP Conditions**

| Program Name | (A) Number Receiving at Least One Screen | (B) Number Presumptive Positive Screens | (C) Number Confirmed Cases | (D) Number Referred for Treatment |
|---|---|---|---|---|
| Core RUSP Conditions | 18,344 (99.5%) | 953 | 27 | 27 (100.0%) |

| Program Name(s) | | | | |
|---|---|---|---|---|
| Propionic acidemia | Methylmalonic acidemia (methylmalonyl-CoA mutase) | Methylmalonic acidemia (cobalamin disorders) | Isovaleric acidemia | 3-Methylcrotonyl-CoA carboxylase deficiency |
| 3-Hydroxy-3-methyglutaric aciduria | Holocarboxylase synthase deficiency | ß-Ketothiolase deficiency | Glutaric acidemia type I | Carnitine uptake defect/carnitine transport defect |
| Medium-chain acyl-CoA dehydrogenase deficiency | Very long-chain acyl-CoA dehydrogenase deficiency | Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency | Trifunctional protein deficiency | Argininosuccinic aciduria |
| Citrullinemia, type I | Maple syrup urine disease | Homocystinuria | Classic phenylketonuria | Tyrosinemia, type I |
| Primary congenital hypothyroidism | Congenital adrenal hyperplasia | S,S disease (Sickle cell anemia) | S, βeta-thalassemia | S,C disease |
| Biotinidase deficiency | Critical congenital heart disease | Cystic fibrosis | Hearing loss | Severe combined immunodeficiences |
| Classic galactosemia | Adrenoleukodystrophy | Mucopolysaccharidosis, type I | Propionic acidemia | |

**2. Other Newborn Screening Tests**

None

**3. Screening Programs for Older Children & Women**

None

### 4. Long-Term Follow-Up

Children are monitored for at least a year or longer (up to 21 years old) if needed. Length of time depends on medical condition, health status of child, and social or other issues. This is done by the NBMS staff; CSHNB Nurses, Nutritionist, or Social Workers; or Public Health Nurses.

**Form Notes for Form 4:**

None

**Field Level Notes for Form 4:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Total Births by Occurrence** |
| | **Fiscal Year:** | **2015** |
| | **Column Name:** | **Total Births by Occurrence Notes** |
| | **Field Note:** None | |

**Data Alerts: None**

## Form 5a
## Unduplicated Count of Individuals Served under Title V

### State: Hawaii

### Reporting Year 2015

| | | Primary Source of Coverage | | | | |
|---|---|---|---|---|---|---|
| Types Of Individuals Served | (A) Title V Total Served | (B) Title XIX % | (C) Title XXI % | (D) Private / Other % | (E) None % | (F) Unknown % |
| 1. Pregnant Women | 1,594 | 4.8 | 0.0 | 0.9 | 0.3 | 94.0 |
| 2. Infants < 1 Year of Age | 18,344 | 33.0 | 0.0 | 62.0 | 0.0 | 5.0 |
| 3. Children 1 to 22 Years of Age | 12,969 | 18.8 | 0.0 | 40.9 | 15.9 | 24.4 |
| 4. Children with Special Health Care Needs | 7,554 | 44.3 | 0.0 | 36.3 | 0.7 | 18.7 |
| 5. Others | 10,540 | 0.0 | 0.0 | 0.0 | 0.0 | 100.0 |
| Total | 51,001 | | | | | |

**Form Notes for Form 5a:**

Data reported for Form 5a are from the state funded portions of the following programs:Primary Care Contracts, Perinatal and Family Planning Services, Sexual Violence Prevention Program, Home Visiting, Family Strengthening Programs: Home Reach, Parent Line, Keiki Play, Children with Special Health Needs Program, 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.

**Field Level Notes for Form 5a:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Pregnant Women Total Served** |
| | **Fiscal Year:** | **2015** |
| | **Field Note:** Programs that contributed to this count of pregnant women include Perinatal and Family Planning Services, and Home Visiting | |
| 2. | **Field Name:** | **Infants Less Than One YearTotal Served** |
| | **Fiscal Year:** | **2015** |
| | **Field Note:** Programs that contributed to this count of infants include Primary Care Contracts, Home Visiting, Parent Line, and Family Strengthening Programs: Home Reach, Newborn Metabolic Screening. The estimate for number served was based on Newborn Metabolic Screening programs as that covers 99.5% of all births in the state, have information on primary source of coverage, and are unable to provide counts for total unduplicated from those served in other programs listed. | |
| 3. | **Field Name:** | **Children 1 to 22 Years of Age** |
| | **Fiscal Year:** | **2015** |
| | **Field Note:** Programs that contributed to this count of children 1-22 years of age include Primary Care Contracts, Perinatal and Family Planning Services, Sexual Violence Prevention Program,Home Visiting, Hawai'i (Big Island) District Health Office) and Family Strengthening Programs: Mobile Outreach Program, Parent Line, and Home Reach. | |
| 4. | **Field Name:** | **Children with Special Health Care Needs** |
| | **Fiscal Year:** | **2015** |
| | **Field Note:** Programs that contributed to this count of pregnant women include Kauaii District Health Office and Hawaii (Big Island) District Health Office. | |
| 5. | **Field Name:** | **Others** |
| | **Fiscal Year:** | **2015** |

**Field Note:**
Others included Adults Over 22 years. Programs that contributed to this count of pregnant women include Sexual Violence Prevention Program and Family Strengthening Programs: Mobile Outreach, Parent Line, and Home Reach.

## Form 5b
## Total Recipient Count of Individuals Served by Title V

### State: Hawaii

### Reporting Year 2015

| Types Of Individuals Served | Total Served |
|---|---|
| 1. Pregnant Women | 18,506 |
| 2. Infants < 1 Year of Age | 18,344 |
| 3. Children 1 to 22 Years of Age | 394,877 |
| 4. Children with Special Health Care Needs | 17,511 |
| 5. Others | 156,045 |
| **Total** | 605,283 |

### Form Notes for Form 5b:

None

### Field Level Notes for Form 5b:

| | | |
|---|---|---|
| 1. | **Field Name:** | **Pregnant Women** |
| | **Fiscal Year:** | **2015** |
| | **Field Note:** Estimates based on total number of births in calendar year 2014. | |
| 2. | **Field Name:** | **Infants Less Than One Year** |
| | **Fiscal Year:** | **2015** |
| | **Field Note:** Estimates based on Number of Newborns screened in FY 2015 | |
| 3. | **Field Name:** | **Children 1 to 22 Year of Age** |
| | **Fiscal Year:** | **2015** |
| | **Field Note:** Estimate based on Census Estimate | |
| 4. | **Field Name:** | **Children With Special Health Care Needs** |
| | **Fiscal Year:** | **2015** |
| | **Field Note:** Percentage of Estimated CSHCN population served by CSHNB | |
| 5. | **Field Name:** | **Others** |
| | **Fiscal Year:** | **2015** |
| | **Field Note:** Census Estimate based on households with children | |
| 6. | **Field Name:** | **Total Served** |
| | **Fiscal Year:** | **2015** |
| | **Field Note:** Estimates for individuals are based on census data and vital statistics as there was no way to calculate an unduplicated count based on program participation. | |

## Form 6
## Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

## State: Hawaii

## Reporting Year 2015

### 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 | 18,506 | 4,771 | 382 | 18 | 4,853 | 1,786 | 6,598 | 98 |
| Title V Served | 18,209 | 4,695 | 376 | 18 | 4,775 | 1,757 | 6,492 | 96 |
| Eligible for Title XIX | 8,042 | 1,221 | 91 | 82 | 2,256 | 2,303 | 0 | 2,089 |
| 2. Total Infants in State | 13,767 | 824 | 622 | 17 | 5,601 | 6,071 | 0 | 632 |
| Title V Served | 13,547 | 811 | 612 | 17 | 5,511 | 5,974 | 0 | 622 |
| Eligible for Title XIX | 9,385 | 102 | 33 | 22 | 449 | 228 | 0 | 8,551 |

### 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 | 15,696 | 2,754 | 56 | 18,506 |
| Title V Served | 15,445 | 2,710 | 54 | 18,209 |
| Eligible for Title XIX | 0 | 0 | 8,042 | 8,042 |
| 2. Total Infants in State | 7,676 | 6,091 | 0 | 13,767 |
| Title V Served | 7,553 | 5,994 | 0 | 13,547 |
| Eligible for Title XIX | 0 | 0 | 9,385 | 9,385 |

### Form Notes for Form 6:

None

### Field Level Notes for Form 6:

| | | |
|---|---|---|
| 1. | **Field Name:** | **1. Total Deliveries in State** |
| | **Fiscal Year:** | **2015** |
| | **Column Name:** | **Total All Races** |
| | **Field Note:**<br>Information obtained from maternal race as reported in 2014 vital statistics birth certificate data and limited to those births to residents of Hawaii based on maternal residence. | |
| 2. | **Field Name:** | **1. Title V Served** |
| | **Fiscal Year:** | **2015** |
| | **Column Name:** | **Total All Races** |
| | **Field Note:**<br>Used overall estimate of newborn metabolic screening percentage (98.4%) in 2014 applied to overall total and each race group. | |
| 3. | **Field Name:** | **1. Eligible for Title XIX** |
| | **Fiscal Year:** | **2015** |
| | **Column Name:** | **Total All Races** |
| | **Field Note:**<br>Data source: Data from Hawaii Medicaid program and reflects unduplicated clients served.<br>Note: Collection of race differs between that reported for Title V served and those reported for Title XIX so are not directly comparable. For example, the number of clients of more than one race was not provided by the Hawaii Medicaid Program.<br>Note: Data on ethnicity was not provided by the Hawaii Medicaid Program. | |
| 4. | **Field Name:** | **2. Total Infants in State** |
| | **Fiscal Year:** | **2015** |
| | **Column Name:** | **Total All Races** |
| | **Field Note:**<br>Latest data available from Hawaii Household Survey is 2011. Tile V served estimated based on the proportion of infants receiving newborn metabolic screening (98.4% in 2015).<br>Note: Collection of race varies from that reported from vital statistics so not directly comparable. For example, more than one race reported was not available from data requested. | |
| 5. | **Field Name:** | **2. Title V Served** |
| | **Fiscal Year:** | **2015** |

| | | |
|---|---|---|
| | **Column Name:** | **Total All Races** |
| | **Field Note:**<br>Used overall estimate of newborn metabolic screening percentage (98.4%) in 2014 applied to overall total and each race group. | |
| 6. | **Field Name:** | **2. Eligible for Title XIX** |
| | **Fiscal Year:** | **2015** |
| | **Column Name:** | **Total All Races** |
| | **Field Note:**<br>Data source: Data from Hawaii Medicaid program and reflects unduplicated clients served.<br>Note: Collection of race differs between that reported for Title V served and those reported for Title XIX so are not directly comparable. For example, the number of clients of more than one race was not provided by the Hawaii Medicaid Program.<br>Note: Data on ethnicity was not provided by the Hawaii Medicaid Program. | |

## Form 7
## State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

### State: Hawaii

| A. State MCH Toll-Free Telephone Lines | 2017 Application Year | 2015 Reporting Year |
|---|---|---|
| 1. State MCH Toll-Free "Hotline" Telephone Number | (800) 816-1222 | (800) 816-1222 |
| 2. State MCH Toll-Free "Hotline" Name | The Parent Line | The Parent Line |
| 3. Name of Contact Person for State MCH "Hotline" | 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" | | 1,826 |

| B. Other Appropriate Methods | 2017 Application Year | 2015 Reporting Year |
|---|---|---|
| 1. Other Toll-Free "Hotline" Names | Early Intervention Referral Line | Early Intervention Referral Line |
| 2. Number of Calls on Other Toll-Free "Hotlines" | | 3,125 |
| 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 | | 654 |
| 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:**

Note: State Title V program website hits reflects time period Oct 1, 2015-July 13, 2016.

## Form 8
## State MCH and CSHCN Directors Contact Information

### State: Hawaii

| 1. Title V Maternal and Child Health (MCH) Director | |
|---|---|
| Name | Matthew Shim, Ph.D., M.P.H |
| Title | Chief, Family Health Services Division |
| Address 1 | 1250 Punchbowl St |
| Address 2 | |
| City/State/Zip | Honolulu / HI / 96813 |
| Telephone | (808) 586-4122 |
| Extension | |
| Email | Matthew.Shim@doh.hawaii.gov |

| 2. Title V Children with Special Health Care Needs (CSHCN) Director | |
|---|---|
| Name | Patricia Heu, M.D. |
| Title | Chief, Children with Special Health Needs Branch |
| Address 1 | 741 Sunset Ave |
| Address 2 | CSHNP |
| City/State/Zip | Honolulu / HI / 96816 |
| Telephone | (808) 733-9070 |
| Extension | |
| Email | patricia.heu@doh.hawaii.gov |

| 3. State Family or Youth Leader (Optional) | |
|---|---|
| Name | Leolinda Parlin |
| Title | Director, Hilopaa Family to Family Health Informat |
| Address 1 | 1319 Punahou St. Ste 739 |
| Address 2 | |
| City/State/Zip | Honolulu / HI / 96826 |
| Telephone | (808) 791-3467 |
| Extension | |
| Email | leo@hilopaa.org |

**Form Notes for Form 8:**

None

## Form 9
## List of MCH Priority Needs

### State: Hawaii

### Application Year 2017

| No. | Priority Need |
|---|---|
| 1. | Promote reproductive life planning |
| 2. | Reduce the rate of infant mortality |
| 3. | Improve the percentage of children screened early and continuously age 0-5 years for developmental delay |
| 4. | Reduce the rate of child abuse and neglect with special attention on ages 0-5 years. |
| 5. | Improve the percentage of youth with special health care needs ages 14-21 years who receive services necessary to make transitions to adult health care. |
| 6. | Improve the oral health of children and pregnant women. |
| 7. | Improve the healthy development, health, safety, and well-being of adolescents |
| 8. | Improve access to services through telehealth |
| 9. | Improve family and consumer engagement in Title V Programs. |
| 10. | Improve partner engagement in Family Health Services Division (FHSD). |

## Form 9 State Priorities-Needs Assessment Year - Application Year 2016

| No. | Priority Need | Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period) | Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure |
|---|---|---|---|
| 1. | Promote reproductive life planning | Continued | |
| 2. | Reduce the rate of infant mortality | New | |
| 3. | Improve the percentage of children screened early and continuously age 0-5 years for developmental delay | Continued | |
| 4. | Reduce the rate of child abuse and neglect with special attention on ages 0-5 years. | Continued | |
| 5. | Improve the percentage of youth with special health care needs ages 14-21 years who receive services necessary to make transitions to adult health care. | Continued | |
| 6. | Improve the oral health of children and pregnant women. | Continued | |
| 7. | Improve the healthy development, health, safety, and well-being of adolescents | New | |
| 8. | Improve access to services through telehealth | New | |

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

None

**Form 10a**
**National Outcome Measures (NOMs)**

**State: Hawaii**

**Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.**

None

**NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 77.9 % | 0.3 % | 13,696 | 17,578 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 1 - Notes:**

None

**Data Alerts: None**

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

**Data Source: State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2013 | 125.8 | 9.1 % | 195 | 15,503 |
| 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 | 6.8 % | 113 | 15,797 |
| 2008 | 73.5 | 6.8 % | 119 | 16,199 |

**Legends:**

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 2 - Notes:**

None

**Data Alerts: None**

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

**FAD Not Available for this measure.**

| State Provided Data | |
|---|---|
| | **2015** |
| **Annual Indicator** | 13.8 |
| **Numerator** | 13 |
| **Denominator** | 94,155 |
| **Data Source** | Vital Statistics. |
| **Data Source Year** | 2010-2014 |

### NOM 3 - Notes:

Indicators are provided in 5 year aggregate and reflects maternal deaths and births to mothers who were residents of Hawaii. Maternal Deaths based on an underlying cause of death based on WHO convention for maternal mortality with ICD codes A34, O00-O95, O98-O99.

### Data Alerts: None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 7.9 % | 0.2 % | 1,462 | 18,526 |
| 2013 | 8.2 % | 0.2 % | 1,562 | 18,970 |
| 2012 | 8.1 % | 0.2 % | 1,542 | 18,975 |
| 2011 | 8.2 % | 0.2 % | 1,557 | 18,947 |
| 2010 | 8.4 % | 0.2 % | 1,584 | 18,972 |
| 2009 | 8.4 % | 0.2 % | 1,592 | 18,872 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4.1 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 1.3 % | 0.1 % | 243 | 18,526 |
| 2013 | 1.4 % | 0.1 % | 263 | 18,970 |
| 2012 | 1.2 % | 0.1 % | 231 | 18,975 |
| 2011 | 1.2 % | 0.1 % | 232 | 18,947 |
| 2010 | 1.2 % | 0.1 % | 222 | 18,972 |
| 2009 | 1.4 % | 0.1 % | 264 | 18,872 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4.2 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 6.6 % | 0.2 % | 1,219 | 18,526 |
| 2013 | 6.9 % | 0.2 % | 1,299 | 18,970 |
| 2012 | 6.9 % | 0.2 % | 1,311 | 18,975 |
| 2011 | 7.0 % | 0.2 % | 1,325 | 18,947 |
| 2010 | 7.2 % | 0.2 % | 1,362 | 18,972 |
| 2009 | 7.0 % | 0.2 % | 1,328 | 18,872 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4.3 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 10.0 % | 0.2 % | 1,862 | 18,537 |
| 2013 | 10.2 % | 0.2 % | 1,928 | 18,959 |
| 2012 | 9.9 % | 0.2 % | 1,885 | 18,964 |
| 2011 | 9.9 % | 0.2 % | 1,880 | 18,938 |
| 2010 | 10.5 % | 0.2 % | 1,985 | 18,953 |
| 2009 | 11.2 % | 0.2 % | 2,094 | 18,785 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 5.1 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 2.4 % | 0.1 % | 444 | 18,537 |
| 2013 | 2.6 % | 0.1 % | 498 | 18,959 |
| 2012 | 2.5 % | 0.1 % | 472 | 18,964 |
| 2011 | 2.6 % | 0.1 % | 497 | 18,938 |
| 2010 | 2.8 % | 0.1 % | 521 | 18,953 |
| 2009 | 2.8 % | 0.1 % | 529 | 18,785 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 5.2 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 7.7 % | 0.2 % | 1,418 | 18,537 |
| 2013 | 7.5 % | 0.2 % | 1,430 | 18,959 |
| 2012 | 7.5 % | 0.2 % | 1,413 | 18,964 |
| 2011 | 7.3 % | 0.2 % | 1,383 | 18,938 |
| 2010 | 7.7 % | 0.2 % | 1,464 | 18,953 |
| 2009 | 8.3 % | 0.2 % | 1,565 | 18,785 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 5.3 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 27.6 % | 0.3 % | 5,115 | 18,537 |
| 2013 | 26.5 % | 0.3 % | 5,024 | 18,959 |
| 2012 | 26.4 % | 0.3 % | 5,012 | 18,964 |
| 2011 | 27.0 % | 0.3 % | 5,104 | 18,938 |
| 2010 | 26.9 % | 0.3 % | 5,089 | 18,953 |
| 2009 | 28.4 % | 0.3 % | 5,326 | 18,785 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 6 - Notes:**

None

**Data Alerts: None**

**NOM 7 - Percent of non-medically indicated early elective deliveries**

**Data Source: CMS Hospital Compare**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014/Q2-2015/Q1 | 2.0 % | | | |
| 2014/Q1-2014/Q4 | 4.0 % | | | |
| 2013/Q4-2014/Q3 | 5.0 % | | | |
| 2013/Q3-2014/Q2 | 6.0 % | | | |
| 2013/Q2-2014/Q1 | 7.0 % | | | |

**Legends:**

Indicator results were based on a shorter time period than required for reporting

**NOM 7 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 ϟ | 20.4 % ϟ | 15 ϟ | 18,987 ϟ |
| 2012 | 63.2 ϟ | 18.3 % ϟ | 12 ϟ | 18,980 ϟ |
| 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

ϟ 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 |
|---|---|---|---|---|
| 2012 | 7.9 % | 0.9 % | 1,416 | 17,864 |
| 2011 | 6.9 % | 0.8 % | 1,267 | 18,437 |
| 2010 | 7.2 % | 0.8 % | 1,328 | 18,461 |
| 2009 | 6.7 % | 0.8 % | 1,230 | 18,374 |
| 2008 | 6.3 % | 0.6 % | 1,167 | 18,459 |
| 2007 | 6.0 % | 0.6 % | 1,107 | 18,342 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 10 - Notes:**

None

**Data Alerts: None**

**NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations**

**Data Source: State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2013 | 3.9 | 0.5 % | 60 | 15,503 |
| 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 |
|---|---|---|---|---|
| 2014 | 14.5 | 3.0 % | 23 | 158,910 |
| 2013 | 20.2 | 3.6 % | 32 | 158,268 |
| 2012 | 10.9 | 2.7 % | 17 | 155,558 |
| 2011 | 16.8 | 3.3 % | 26 | 154,442 |
| 2010 | 14.4 | 3.1 % | 22 | 153,004 |
| 2009 | 19.3 | 3.6 % | 29 | 150,364 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 15 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 20.9 | 3.6 % | 34 | 162,896 |
| 2013 | 25.2 | 3.9 % | 41 | 162,519 |
| 2012 | 27.7 | 4.1 % | 45 | 162,427 |
| 2011 | 30.3 | 4.3 % | 50 | 165,114 |
| 2010 | 26.9 | 4.0 % | 45 | 167,533 |
| 2009 | 31.5 | 4.3 % | 53 | 168,494 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.1 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2012_2014 | 8.3 | 1.9 % | 20 | 242,273 |
| 2011_2013 | 11.4 | 2.2 % | 28 | 245,750 |
| 2010_2012 | 11.1 | 2.1 % | 28 | 251,412 |
| 2009_2011 | 12.5 | 2.2 % | 32 | 256,302 |
| 2008_2010 | 11.6 | 2.1 % | 30 | 259,537 |
| 2007_2009 | 10.8 | 2.0 % | 28 | 260,274 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.2 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2012_2014 | 8.3 | 1.9 % | 20 | 242,273 |
| 2011_2013 | 9.0 | 1.9 % | 22 | 245,750 |
| 2010_2012 | 9.6 | 2.0 % | 24 | 251,412 |
| 2009_2011 | 11.3 | 2.1 % | 29 | 256,302 |
| 2008_2010 | 11.9 | 2.1 % | 31 | 259,537 |
| 2007_2009 | 10.8 | 2.0 % | 28 | 260,274 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.1 - Percent of children with special health care needs**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 17.1 % | 1.2 % | 51,895 | 304,085 |
| 2007 | 17.9 % | 1.2 % | 50,137 | 279,867 |
| 2003 | 15.0 % | 1.0 % | 44,310 | 296,099 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 17.1 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2009_2010 | 22.7 % | 2.1 % | 7,254 | 31,949 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 17.2 - Notes:**

None

**Data Alerts: None**

**NOM 17.3 - Percent of children diagnosed with an autism spectrum disorder**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 1.3 % | 0.4 % | 3,373 | 252,498 |
| 2007 | 0.6 % | 0.2 % | 1,416 | 229,332 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 17.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.4 - Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 5.7 % | 0.8 % | 14,236 | 251,557 |
| 2007 | 4.2 % | 0.7 % | 9,502 | 228,582 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 17.4 - Notes:**

None

**Data Alerts: None**

**NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 58.7 % | 6.2 % | 11,474 | 19,553 |
| 2007 | 63.0 % | 6.6 % | 8,602 | 13,660 |
| 2003 | 67.8 % | 5.9 % | 10,641 | 15,687 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 18 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 86.0 % | 1.1 % | 261,333 | 303,854 |
| 2007 | 86.7 % | 1.1 % | 241,938 | 279,051 |
| 2003 | 86.7 % | 1.0 % | 256,361 | 295,749 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 19 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 27.4 % | 2.0 % | 36,008 | 131,228 |
| 2007 | 28.5 % | 2.1 % | 34,313 | 120,448 |
| 2003 | 26.9 % | 1.8 % | 34,448 | 128,172 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**Data Source: WIC**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 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 |
|---|---|---|---|---|
| 2014 | 2.0 % | 0.3 % | 6,246 | 307,392 |
| 2013 | 3.2 % | 0.6 % | 9,896 | 306,669 |
| 2012 | 2.9 % | 0.5 % | 8,844 | 301,575 |
| 2011 | 3.9 % | 0.6 % | 11,813 | 304,365 |
| 2010 | 3.7 % | 0.6 % | 11,134 | 302,473 |
| 2009 | 2.6 % | 0.5 % | 7,498 | 288,177 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 21 - Notes:**

None

**Data Alerts: None**

**NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)**

**Data Source: National Immunization Survey (NIS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 73.7 % | 3.3 % | 19,437 | 26,371 |
| 2013 | 66.5 % | 4.2 % | 17,471 | 26,291 |
| 2012 | 80.2 % | 2.8 % | 21,101 | 26,326 |
| 2011 | 74.8 % | 3.7 % | 20,233 | 27,044 |
| 2010 | 63.7 % | 3.3 % | 17,732 | 27,823 |
| 2009 | 46.7 % | 3.9 % | 12,642 | 27,068 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.1 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Immunization Survey (NIS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014_2015 | 74.4 % | 1.9 % | 206,844 | 278,016 |
| 2013_2014 | 70.4 % | 2.6 % | 194,717 | 276,586 |
| 2012_2013 | 69.7 % | 3.3 % | 199,548 | 286,207 |
| 2011_2012 | 66.6 % | 4.0 % | 178,392 | 267,854 |
| 2010_2011 | 70.0 % | 6.4 % | 181,808 | 259,726 |
| 2009_2010 | 67.3 % | 2.4 % | 184,988 | 274,870 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.2 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Immunization Survey (NIS) - Female**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 60.4 % | 4.4 % | 23,739 | 39,293 |
| 2013 | 52.7 % | 5.2 % | 20,537 | 38,995 |
| 2012 | 64.6 % | 4.8 % | 26,054 | 40,328 |
| 2011 | 73.1 % | 4.1 % | 29,710 | 40,620 |
| 2010 | 62.7 % | 4.8 % | 24,485 | 39,075 |
| 2009 | 65.0 % | 4.8 % | 24,533 | 37,761 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**Data Source: National Immunization Survey (NIS) - Male**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 56.5 % | 4.4 % | 23,138 | 40,967 |
| 2013 | 39.7 % | 4.6 % | 16,275 | 41,043 |
| 2012 | 43.1 % | 4.9 % | 18,123 | 42,050 |
| 2011 | 11.7 % | 2.8 % | 4,957 | 42,417 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.3 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Immunization Survey (NIS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 82.3 % | 2.5 % | 66,040 | 80,260 |
| 2013 | 80.2 % | 2.7 % | 64,200 | 80,038 |
| 2012 | 74.1 % | 3.0 % | 61,021 | 82,379 |
| 2011 | 67.7 % | 3.2 % | 56,199 | 83,036 |
| 2010 | 58.1 % | 3.2 % | 47,269 | 81,309 |
| 2009 | 46.1 % | 3.5 % | 36,222 | 78,650 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.4 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Immunization Survey (NIS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 77.7 % | 2.7 % | 62,358 | 80,260 |
| 2013 | 75.0 % | 3.1 % | 60,003 | 80,038 |
| 2012 | 70.4 % | 3.2 % | 58,019 | 82,379 |
| 2011 | 70.2 % | 3.0 % | 58,282 | 83,036 |
| 2010 | 64.5 % | 3.0 % | 52,417 | 81,309 |
| 2009 | 51.0 % | 3.5 % | 40,094 | 78,650 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.5 - Notes:**

None

**Data Alerts: None**

## Form 10a
## National Performance Measures (NPMs)

## State: Hawaii

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 62.0 | 63.0 | 64.0 | 64.0 | 65.0 | 65.0 |

### Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 61.1 % | 2.0 % | 146,768 | 240,110 |
| 2013 | 62.3 % | 1.9 % | 150,121 | 241,032 |
| 2012 | 61.6 % | 1.9 % | 145,213 | 235,637 |
| 2011 | 55.0 % | 2.1 % | 128,425 | 233,413 |
| 2010 | 54.8 % | 2.2 % | 120,779 | 220,266 |
| 2009 | 56.7 % | 2.2 % | 126,764 | 223,508 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

### Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2016**

**Field Note:**
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2014: 61.1%). The 2020 goal was carried forward to 2021.

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 90.0 | 91.0 | 92.0 | 93.0 | 94.0 | 94.0 |

### Data Source: National Immunization Survey (NIS)

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2012 | 85.0 % | 3.2 % | 13,926 | 16,385 |
| 2011 | 89.5 % | 2.5 % | | |
| 2010 | 87.8 % | 2.3 % | | |
| 2009 | 84.9 % | 3.6 % | | |
| 2008 | 85.9 % | 2.1 % | | |
| 2007 | 87.0 % | 2.3 % | | |

**Legends:**

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

### Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2016**

**Field Note:**
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2012: 85.0%). The 2020 goal was carried forward to 2021.

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 27.0 | 27.0 | 27.0 | 27.0 | 28.0 | 28.0 |

### Data Source: National Immunization Survey (NIS)

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2012 | 27.1 % | 3.5 % | 4,389 | 16,213 |
| 2011 | 26.4 % | 3.2 % | | |
| 2010 | 22.4 % | 2.8 % | | |
| 2009 | 22.9 % | 2.8 % | | |
| 2008 | 22.6 % | 2.5 % | | |
| 2007 | 18.0 % | 2.3 % | | |

**Legends:**

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

### Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2016**

**Field Note:**
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2012: 87.1%). The 2020 goal was carried forward to 2021.

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 79.0 | 79.0 | 80.0 | 81.0 | 82.0 | 82.0 |

### Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2012 | 82.0 % | 1.3 % | 14,851 | 18,103 |
| 2011 | 78.1 % | 1.4 % | 14,329 | 18,339 |
| 2010 | 74.5 % | 1.4 % | 13,587 | 18,235 |
| 2009 | 76.9 % | 1.3 % | 13,851 | 18,001 |
| 2008 | 71.6 % | 1.1 % | 13,095 | 18,298 |
| 2007 | 71.7 % | 1.1 % | 12,825 | 17,878 |

**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

### Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2016**

**Field Note:**
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2012: 82.0%). The 2020 goal was carried forward to 2021.

**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 | 2021 |
| Annual Objective | 39.0 | 40.0 | 40.0 | 41.0 | 41.0 | 41.0 |

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 38.9 % | 3.1 % | 31,440 | 80,906 |
| 2007 | 27.3 % | 3.0 % | 21,477 | 78,824 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1. **Field Name:** **2016**

**Field Note:**
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2011-2012: 38.9%). The 2020 goal was carried forward to 2021.

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 149.0 | 148.0 | 147.0 | 145.0 | 142.0 | 142.0 |

### Data Source: State Inpatient Databases (SID) - CHILD

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2013 | 150.1 | 9.2 % | 265 | 176,558 |
| 2012 | 143.3 | 8.9 % | 258 | 180,003 |
| 2011 | 165.4 | 9.6 % | 299 | 180,771 |
| 2010 | 148.9 | 9.4 % | 250 | 167,883 |
| 2009 | 176.1 | 10.4 % | 289 | 164,111 |
| 2008 | 141.7 | 9.1 % | 240 | 169,436 |

**Legends:**

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

### Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2016**

**Field Note:**
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2013: 150). The 2020 goal was carried forward to 2021.

**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 | 2021 |
| Annual Objective | 83.0 | 83.0 | 84.0 | 85.0 | 86.0 | 86.0 |

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 82.2 % | 2.0 % | 83,403 | 101,416 |
| 2007 | 87.9 % | 1.6 % | 80,537 | 91,602 |
| 2003 | 72.3 % | 2.1 % | 71,854 | 99,342 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1. **Field Name:** **2016**

**Field Note:**
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2011-2012: 82.2%). The 2020 goal was carried forward to 2021.

**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 | 2021 |
| Annual Objective | 36.0 | 36.0 | 37.0 | 38.0 | 39.0 | 39.0 |

**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 | 37.3 % | 3.4 % | 4,714 | 12,643 |
| 2005_2006 | 39.4 % | 3.3 % | 5,024 | 12,766 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1. **Field Name:** **2016**

**Field Note:**
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2009-2010: 37.3%). The 2020 goal was carried forward to 2021.

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 38.0 | 40.0 | 41.0 | 42.0 | 45.0 | 45.0 |

### Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2012 | 42.5 % | 1.7 % | 7,823 | 18,403 |
| 2011 | 37.0 % | 1.6 % | 6,817 | 18,448 |
| 2010 | 33.8 % | 1.6 % | 6,122 | 18,126 |
| 2009 | 33.5 % | 1.5 % | 6,035 | 18,010 |

**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

### Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2016**

**Field Note:**
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2012: 42.5%). The 2020 goal was carried forward to 2021.

### 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 | 2021 |
| Annual Objective | 84.0 | 84.0 | 85.0 | 86.0 | 87.0 | 87.0 |

### Data Source: National Survey of Children's Health (NSCH)

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 83.1 % | 1.2 % | 236,960 | 285,187 |
| 2007 | 86.9 % | 1.1 % | 225,601 | 259,718 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

### Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2016**

**Field Note:**
The annual objectives have been set to show a 5% improvement over 5 years from the baseline (2011-2012: 83.1%). The 2020 goal was carried forward to 2021.

**Form 10a**
**State Performance Measures (SPMs)**

**State: Hawaii**

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

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 22.0 | 34.0 | 44.0 | 56.0 | 68.0 |

**Field Level Notes for Form 10a SPMs:**

None

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

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 29.0 | 34.0 | 39.0 | 44.0 | 49.0 |

**Field Level Notes for Form 10a SPMs:**

1. **Field Name:** **2021**

**Field Note:**
Objectives were set by the Title V Planning Committee based on baseline data (24%), expected progress, considering the work and program changes that are needed.

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

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 18.0 | 23.0 | 28.0 | 33.0 | 38.0 |

**Field Level Notes for Form 10a SPMs:**

1. **Field Name:** **2021**

**Field Note:**
Objectives were set by the Title V Planning Committee based on baseline data (13%), expected progress, considering the work and program changes that are needed.

## Form 10a
## Evidence-Based or-Informed Strategy Measures (ESMs)

## State: Hawaii

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

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 30.0 | 30.0 | 29.0 | 29.0 | 28.0 |

### Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

**Field Note:**
5% improvement over 5 years from baseline (2014: 29.9%)

### ESM 4.1 - Percent of WIC infants ever breastfed

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 95.0 | 95.0 | 96.0 | 97.0 | 98.0 |

### Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

**Field Note:**
5% improvement over 5 years from baseline (94.2% in 2015)

### ESM 5.1 - Percent of birthing hospitals with current AAP safe sleep protocols

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

### Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

**Field Note:**
Objectives were set by Safe Sleep Hawaii considering baseline data and the expected progress over the next 5 years. Safe Sleep Hawaii did a baseline assessment and identified a baseline of 46% in 2015 (6/13=46%)

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

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | Yes | Yes | Yes | Yes | Yes |

### Field Level Notes for Form 10a ESMs:

None

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

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

### Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

**Field Note:**
No baseline data available so not able to develop 5 year objectives. This is a new measure within the Home Visiting Program.

### ESM 10.1 - Development and dissemination of a teen-centered, Adolescent Resource Toolkit (ART) with corresponding continuing education series (Science) to primary care providers to increase knowledge and skill in implementing the adolescent well-care visit

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 15.0 | 21.0 | 33.0 | 42.0 | 48.0 |

### Field Level Notes for Form 10a ESMs:

None

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

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 10.0 | 14.0 | 18.0 | 22.0 | 24.0 |

### Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

**Field Note:**
Objectives were set by the Children/Youth with Special Health Needs Section (CYSHNS) staff based on their expected progress, considering the work and program changes that are needed. The CYSHNS staff did a baseline assessment using the Data Collection Form for ESM 12.1 (form can be found in the Supporting Document) and identified a baseline of 4.

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

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | Yes | Yes | Yes | Yes | Yes |

### Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

**Field Note:**

Objectives were set by the Family Health Services team of staff working on oral health. The objectives are based on their expected progress in recruiting, hiring, orienting new oral health program staff. Once the ESM objective is achieved, a new ESM will be developed and submitted.

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

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | Yes | Yes | Yes | Yes | Yes |

### Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

**Field Note:**
Objectives were set by the Department of Health Tele-dentistry project planning committee. The objectives are based on the project work plan which is expected to be completed FFY 2017 . Once the ESM objective is achieved, a new ESM will be developed and submitted.

**Form 10b**
**State Performance Measure (SPM) Detail Sheets**

**State: Hawaii**

**SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers.**
**Population Domain(s) – Cross-Cutting/Life Course**

<table>
<tr><td>Goal:</td><td>Increase the use of telehealth across Title V activities to improve access to services and education for families and providers.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Total Actual Scores from three Telehealth Data Collection Forms</td></tr>
<tr><td>Denominator:</td><td>Total Possible Scores from three Telehealth Data Collection Forms (18, 24, 30)</td></tr>
<tr><td>Unit Type:</td><td>Scale</td></tr>
<tr><td>Unit Number:</td><td>72</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>HP2020 Health Communication & Health Information Technology Goal: Use health communication strategies and health information technology (IT) to improve population health outcomes and health care quality, and to achieve health equity.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>This is a summary of the Data Collection Form that lists 24 strategy components organized by the three areas in telehealth activities:<br>• Infrastructure development<br>• Training/education development<br>• Service development<br>Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 72. Scoring is completed by FHSD staff. The data collection form is attached as a supporting document.</td></tr>
<tr><td>Significance:</td><td>With the reduction in personnel resources, increases in travel costs, and availability of high speed internet and affordable devices, telehealth can be one of the tools to increase access to families and providers while saving costs and travel time. Telehealth can be used to increase access to services for families, care coordination activities, education for providers, and workforce training for public health staff.</td></tr>
</table>

**SPM 2 - The percentage of Family Health Services Division (FHSD) staff that have increased their knowledge on family/consumer engagement.**
**Population Domain(s) – Cross-Cutting/Life Course**

| | |
|---|---|
| **Goal:** | Increase the engagement of families and consumers in FHSD activities. |
| **Definition:** | <table><tr><td>**Numerator:**</td><td>Total number of FHSD staff who have expert level (expert level is defined as “I know the topic quite well and am confident talking to families or others about it”) knowledge about family/consumer engagement: 11</td></tr><tr><td>**Denominator:**</td><td>Total number of staff selected to be part of Title V Planning asked: 46</td></tr><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr></table> |
| **Healthy People 2020 Objective:** | None that are applicable. |
| **Data Sources and Data Issues:** | Although the overall goal is to increase family and consumer engagement in FHSD activities, the data is focused on FHSD staff and will be collected and measured annually on staff knowledge of family/consumer engagement. The other strategies and activities will help address the goal but this measure will be used to assist with workforce development and staff knowledge, attitudes, and skills on engaging these stakeholders. By increasing staff knowledge and skills on the subject, it is anticipated that this will, in turn, lead to staff willingness to engage consumers and families in their work. This will, in turn, lead to greater family and consumer engagement in FHSD and Title V activities.<br><br>In preparation for the annual Title V 2015 meeting, staff were selected by the FHSD Core staff to participate in Title V Strategy meetings and workgroups. These 46 staff were asked to rate their level of knowledge on Family/Consumer engagement according to the following three levels: Expert (“I know the topic quite well and am confident talking to families or others about it”); Intermediate (“I know at least 50% of the topic and I know where I can find more information about it. With help, I am confident I can talk with families or others about it”); Novice (“I am not confident that I know enough about the topic to discuss with others”). This 2015 survey will be used as a baseline in assessing staff knowledge and understanding of the topic. In conjunction with other strategies and activities, this survey will be sent to the same staff to measure the increase of staff knowledge on the subject.<br><br>Data may be compromised if there are changes to the 46 staff that were surveyed (i.e., staffing changes due to retirement, changing positions, finding other employment, etc.). However, the majority of the staff should continue to be with the FHSD and if there are replacements, then this will be noted in the data charts. |
| **Significance:** | Having families and consumers engaged with Title V Programs helps to increase optimal health outcomes for children and families. Benefits include the increased awareness of family needs, increased parent/professional communication, improved policies and responsiveness to family needs, increased availability of families to participate, and increased responsiveness to federal requirements (Title V Tip Sheet: Lessons Learned from MCH & CSHCN Directors, 2002). Engaging families and consumers at various levels – policy and advocacy, program improvement, and public awareness and promotion – can lead to |

| | |
|---|---|
| | mutually strengthening and supportive outcomes for Title V programs and for children and families. Other federal programs have also promoted family and community engagement such as the Office of Head Start, U.S. Department of Education, National Parent Teacher Association. |

**SPM 3 - The percentage of Family Health Services Division (FHSD) staff that have increased their knowledge on Partner Engagement.**
**Population Domain(s) – Cross-Cutting/Life Course**

<table>
<tr><td>Goal:</td><td>Increase the meaningful engagement of partners in FHSD activities.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Total number of FHSD staff who have expert level (expert level is defined as “I know the topic quite well and am confident talking to families or others about it”) knowledge about partner engagement: 6</td></tr>
<tr><td>Denominator:</td><td>Total number of staff selected to be part of Title V Planning asked: 46</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>None that are applicable.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Ithough the overall goal is to increase meaningful partner engagement in FHSD activities, the data is focused on FHSD staff and will be collected and measured annually on staff knowledge of partner engagement. The other strategies and activities will help address the goal but this measure will be used to assist with workforce development and staff knowledge, attitudes, and skills on meaningful engagement of partners. By increasing staff knowledge and skills on the subject, it is anticipated that this will, in turn, lead to staff willingness to engage partners in a meaningful way. This will, in turn, lead to greater partner engagement in FHSD and Title V activities.<br><br>In preparation for the annual Title V 2015 meeting, staff were selected by the FHSD Core staff to participate in Title V Strategy meetings and workgroups. These 46 staff were asked to rate their level of knowledge on Partner Engagement according to the following three levels: Expert (“I know the topic quite well and am confident talking to families or others about it”); Intermediate (“I know at least 50% of the topic and I know where I can find more information about it. With help, I am confident I can talk with families or others about it”); Novice (“I am not confident that I know enough about the topic to discuss with others”). This 2015 survey will be used as a baseline in assessing staff knowledge and understanding of the topic. In conjunction with other strategies and activities, this survey will be sent to the same staff to measure the increase of staff knowledge on the subject.<br><br>Data may be compromised if there are changes to the 46 staff that were surveyed (i.e., staffing changes due to retirement, changing positions, finding other employment, etc.). However, the majority of the staff should continue to be with the FHSD and if there are replacements, then this will be noted in the data charts.</td></tr>
<tr><td>Significance:</td><td>Because of drastic cuts to the State economy in 2009, Hawaii’s Department of Health (DOH) suffered a Reduction In Force (RIF) and a reduction in purchase of service dollars. FHSD had 63.75 permanent positions abolished, which resulted in closure of whole units and programs. FHSD is slowly building its workforce again but many staff had to take on additional responsibilities and focus on immediate program needs and priorities as opposed to continuing their partnership efforts. While some FHSD Programs may work with partners and stakeholders, Hawaii needs to identify a systems’ approach for how this can be done</td></tr>
</table>

comprehensively, consistently, and effectively. Not all programs may see themselves as working with partners and may not see the value in exerting efforts to improve relationships that they may not think exist. Title V stresses the importance of partner engagement but leaves it to States to decide how to best achieve this. Hawaii recognizes its role in public health to work with partners collaboratively for optimal health and development of children, families, and communities.

## Form 10b
## State Outcome Measure (SOM) Detail Sheets

## State: Hawaii

No State Outcome Measures were created by the State.

**Form 10c**
**Evidence-Based or –Informed Strategy Measure (ESM) Detail Sheets**

**State: Hawaii**

## ESM 1.1 - Percent of births with less than 18 months spacing between birth and next conception
## NPM 1 – Percent of women with a past year preventive medical visit

| | |
|---|---|
| **Goal:** | To support reproductive life planning and healthy birth outcomes by increasing intervals of birth spacing (births spaced from 18 month to next conception). |
| **Definition:** | **Numerator:** Number of Births with interval < 18 months between birth and next conception<br>**Denominator:** Total number of Births<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Data source is vital statistics, Office of Health Status Monitoring.<br>Calculation of interval is based on birth certificate data with valid clinical estimate of gestational age of index birth and prior live birth.<br>Pregnancy Interval = ConceptionDate – Last Live Birth (following HRSA CoIIN to reduce infant mortality outcome measure). |
| **Significance:** | Research shows that effective contraception can help with birth spacing, reduce the risk of low-weight and premature births, and support a woman's longer term physical and emotional well-being. The Centers for Disease Control and Prevention has identified Long Acting Reversible Contraception (LARC) as among the most effective family planning methods with a pregnancy rate of less than 1 pregnancy per 100 women in the first year. LARC's intrauterine devices (IUDs) and contraceptive implants are highly effective methods of birth control and can last between 3 and 10 years (depending on the method). Incorporating pregnancy intention screenings in routine and proactive settings where reproductive health age women are likely to be screened every 3 months to a year, regardless of the reason for a women's visit supports the use of One Key Question®(OKQ) and multiple opportunities for these interventions with discussions that can lead to opportunities for preconception care and contraceptive services. References: Department of Health and Human Services, Centers for Medicaid and Medicaid Services, CMCS Informational Bulletin, April 8, 2016, State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception; Augustin Conde Agueldo, MD, MPH; Anyeli Rosas-Bermudez, MPH; Ana Cecilia Kafury-Goeta, MD (2006). Birth Spacing and Risk of Adverse Perinatal Outcomes: A Meta-analysis. JAMA 295 (15): 1809-1823. Trussell J. Contraceptive efficacy. In: Hatcher R, Trussell J, Nelson A, Cates W, Kowal D, Policar M, eds. Contraceptive Technology. 20th ed. New York, NY: Ardent Media; 2011:779-863. Oregon Foundation for Reproductive Health One Key Question®. |

**ESM 4.1 - Percent of WIC infants ever breastfed**
**NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months**

| | |
|---|---|
| **Goal:** | Promote Breastfeeding in all WIC clinics statewide |
| **Definition:** | **Numerator:** Unduplicated number of WIC infants ever breastfed by SFY<br>**Denominator:** Unduplicated number of WIC infants by SFY<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Hawaii WIC Program Data |
| **Significance:** | Breastfeeding is the normative standard for infant feeding and nutrition and can result in improved infant and maternal health outcomes. Given the indisputable short- and long-term advantages of breastfeeding, infant nutrition is considered a public health priority. The American Academy of Pediatrics (AAP) recommends that all infants be exclusively breastfed for about six months with continuation of breastfeeding for one year or longer. Breastfeeding is also encouraged and supported by other agencies such as the United States Department of Agriculture's (USDA) Food and Nutrition Service (FNS).<br><br>However, as rewarding as breastfeeding can be, some women choose not to breastfeed and many women who start breastfeeding often stop when they are faced with challenges. With appropriate guidance and education, women can overcome these obstacles and continue breastfeeding for longer periods.<br><br>WIC is the largest public breastfeeding promotion program in the state and nation, providing mothers with education and support as a core service. Moreover, promoting and/or facilitating community activities that reinforce breastfeeding may allow for more women across the state to have access to the support they need to initiate breastfeeding and continue doing so exclusively for at least 6 months. |

**ESM 5.1 - Percent of birthing hospitals with current AAP safe sleep protocols**
**NPM 5 – Percent of infants placed to sleep on their backs**

| | |
|---|---|
| **Goal:** | Educate mother and family to maintain a safe sleep position & environment for infants. |
| **Definition:** | **Numerator:** Number of birthing hospitals with current AAP safe sleep protocols<br>**Denominator:** Total number of birthing hospitals<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Safe Sleep Hawaii |
| **Significance:** | About 3,500 US infants die suddenly and unexpectedly each year. Theese deaths are referred to as sudden unexpected infant deaths (SUID). SUID are one of the three leading causes of death among infants nationally and in Hawaii (Hayes DK, Calhoun CR, Byers TJ, Chock LR, Heu PL, Tomiyasu DW, Sakamoto DT, and Fuddy LJ. Saving Babies: Reducing Infant Mortality in Hawaii. Hawaii Journal of Medicine and Public Health. 2013. 72 (2): 246-251).<br>Although the causes of death in many of these children can't be explained, most occur while the infant is sleeping in an unsafe sleeping environment.<br>The American Academy of Pediatrics (AAP) expanded their recommendation to focus on safe sleep environments to reduce sleep related infant deaths. One recommendation is directed towards health care professionals, including staff in newborn nurseries and the NICU (AAP, 2011). Ensuring that current and consistent messages are provided by hospital staff to mothers in the hospital can influence infant safe sleep practices. |

**ESM 6.1 - Development and implementation of Data sharing system for FHSD programs conducting developmental screening, referrals, and services**
**NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool**

<table>
<tr><td>Goal:</td><td>Increase the number of children receiving developmental screening, being referred and receiving services among Hawaii Title V direct service programs.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>N/A</td></tr>
<tr><td>Denominator:</td><td>N/A</td></tr>
<tr><td>Unit Type:</td><td>Text</td></tr>
<tr><td>Unit Number:</td><td>Yes/No</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>National Survey of Children’s Health compiles data for developmental screening. However, Hawaii is looking at data specific to the number of children receiving screening and services. Hawaii’s Med-QUEST Division collects information on the Federal Form CMS-416 which is the annual EPSDT Participation Report Form. This is a national form and is used in Centers for Medicare and Medicaid Services and provides statewide data based on claims submitted. However, data is only available on children participating in the Med-QUEST Program, which is approximately 40% of the Hawaii population. While this is significant, this does not provide information on children who have private insurance thus Hawaii does not have a data source for all the children in Hawaii who have received developmental screening in a health care setting. Also, there are other programs and community agencies conducting developmental screening such as home visitors, early childhood programs, and other community agencies. This data is not being systemically reported nor collected.<br><br>Family Health Services Division, the Title V agency, will create a data system to track developmental screening activities for its programs that provide direct/enabling services. The FHSD team established to work on this Title V priority will determine scoring for this measure.</td></tr>
<tr><td>Significance:</td><td>Hawaii is using the ESM to develop a data sharing system within FHSD to collect the number of screenings, referrals, and services provided to children (ages birth-5) in the MIECHV Home Visiting Programs, the CSHNB Hi’ilei Program, and the Early Intervention Section which is the IDEA Part C agency. Once the data sharing system is developed, then Hawaii can actually see the “real” number of children being screened and tracked through referral into services. For Quality Improvement (QI), this data sharing will help pinpoint where increases in screenings, referrals, and follow up are needed. It may also show a need to reduce duplication or monitor where screenings are occurring but referrals are not. Once the system is in place, the ESM will be adjusted to address the needs as identified by the data. Yes refers to whether the data sharing system has been developed and implemented. No refers to the incompletion of the establishment of a data sharing system.<br>Hawaii’s Developmental Screening and Services Workgroup has already identified the programs that will be a part of the data system. The next step to establishing the system is to ensure there are formal agreements between the programs, ensure parent consent and confidentiality will be secured, identifying the data elements that will be collected, developing the communications protocol and meeting frequency to discuss the findings of the data, and the development of a tracking form to monitor the data and progress.<br>Once the data sharing system is established, then Hawaii will be able to establish a baseline</td></tr>
</table>

| | |
|---|---|
| | and use the data to improve linkages between the programs to better capture whether the children who are screened and identified with a risk is receiving the services to support their optimal development. |

**ESM 7.1 - Percent of children in a home visiting program with an injury-related visit to the emergency department since enrollment.**
**NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19**

<table>
<tr><td>Goal:</td><td>Reduce the percent of enrolled children in home visiting with a nonfatal injury-related visits to the emergency department to 1% by 2021.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of parent-reported nonfatal injury-related visits to the emergency department among index children enrolled in home visiting services.</td></tr>
<tr><td>Denominator:</td><td>Number of index children enrolled in a home visiting program</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Home visiting contracted providers collect data on their enrolled children/families, then report to the Department of Health in accordance with HRSA/MCHB funded Maternal Infant Early Childhood Home Visiting (MIECHV) Program Guidelines. The children tracked by this measure represent “index” children who enter MIECHV prenatally or at-birth, but not older siblings or subsequent siblings.</td></tr>
<tr><td>Significance:</td><td>During 2013, approximately 679,000 children were confirmed to be victims of maltreatment. The overall national child victim rate was 9.1 child victims per 1,000 children in the population. (US DHHS/ACF Child Welfare Outcomes Report, 2010-2013)<br><br>Home visiting programs prevent child abuse and neglect, as well as improves maternal and child health, encourages positive parenting, and promotes child development and school readiness.<br><br>Over time, families and home visitors build partnerships and work together to prevent child injuries, child abuse, neglect, or maltreatment, and reduce emergency department visits.</td></tr>
</table>

**ESM 10.1 - Development and dissemination of a teen-centered, Adolescent Resource Toolkit (ART) with corresponding continuing education series (Science) to primary care providers to increase knowledge and skill in implementing the adolescent well-care visit**
**NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

<table>
<tr><td>Goal:</td><td>Increase resources, training and practice improvement support for adolescent health providers to provide well-care visits aligned to Bright Futures.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Numerator: Total Actual Score from Adolescent Health Data Collection Form</td></tr>
<tr><td>Denominator:</td><td>Denominator: Total Possible Score from Adolescent Health Data Collection Form</td></tr>
<tr><td>Unit Type:</td><td>Scale</td></tr>
<tr><td>Unit Number:</td><td>51</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>This is a summary of the Data Collection Form that lists 17 strategy components organized by the following domains:<br>• Adolescent Resource Toolkit<br>• Continuing Education Curriculum Series (Science)<br>• Outreach and Training<br>Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 51. Scoring is completed by Title V staff, with input from ART & Science Workgroup. The data collection form is attached as a supporting document.</td></tr>
<tr><td>Significance:</td><td>Many health plan, provider, parent and adolescent challenges exist which limit access to comprehensive adolescent well care (AWC) visits which include:<br>• Poor utilization of AWC<br>• Perception that the AWC lacks value<br>• Variability in health plan benefit cost share for families of the AWC and follow up services<br>• High utilization of sports physicals instead of AWCInconsistent practices addressing confidentiality<br>• Provider discomfort with mental health, substance abuse, and reproductive health interventions<br>• Lack of knowledge of community resources<br><br>Teen-centered care includes:<br>• Teens’ contraceptive and reproductive health needs are assessed at every visit e.g. emergency contraception is available to male and female adolescents.<br>• Teens receive STD/HIV counseling, testing, and treatment without having an exam.<br>• Mental health, substance use, violence, and other health concerns are assessed and appropriate referrals are made.<br>• Health information disclosed or discussed during a visit is confidential, consistent with state laws and regulations.<br>• Billing procedures maintain teen’s confidentiality.<br>• The health center environment and staff leave teen patients feeling respected and engaged in their health care.<br>• Culturally competent care is provided, and care is sensitive to and respectful of each</td></tr>
</table>

| | |
|---|---|
| | teen's culture, ethnicity, community values, religion, language, educational level, sex, gender, and sexual orientation.<br>• The care provided addresses the unique biologic, cognitive, and psychosocial needs of adolescents.<br>• Conversations between teens and providers are two-way, where teens feel respected and not judged.<br>Everyone knows there's an "ART & Science" in supporting adolescents. Title V will address the documentation of practices and resources through it's "ART" and provide the "Science" support through continuing education training. |

**ESM 12.1 - The degree to which the Title V Children and Youth with Special Health Needs Section (CYSHNS) promotes and/or facilitates transition to adult health care for YSHCN.**
**NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care**

<table>
<tr><td>Goal:</td><td>To increase the degree to which the Title V CYSHNS promotes and/or facilitates transition to adult health care for YSHCN.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Total Actual Score from Transition to Adult Health Care Data Collection Form</td></tr>
<tr><td>Denominator:</td><td>Total Possible Score from Transition to Adult Health Care Data Collection Form (33)</td></tr>
<tr><td>Unit Type:</td><td>Scale</td></tr>
<tr><td>Unit Number:</td><td>33</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>This is a summary of the Data Collection Form that lists 11 strategy components organized by the Six Core Elements of Health Care Transition:<br>• Transition policy<br>• Transition tracking and monitoring<br>• Transition readiness<br>• Transition planning<br>• Transfer of care<br>• Transition completion.<br>Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 33. Scoring is completed by CSHNP staff, with input from Hilopaa Family to Family Health Information Center. The data collection form is attached as a supporting document.</td></tr>
<tr><td>Significance:</td><td>CSHNP is addressing Got Transition’s Six Core Elements of Health Care Transition 2.0. Strategy components were adapted for integration as part of CSHNP services to support youth/families in preparing for transition to adult health care.<br><br>Health and health care are important to making successful transitions. The majority of YSHCN do not receive needed support to transition from pediatric to adult health care. In addition, YSHCN, compared to those without special health care needs, are less likely to complete high school, attend college, or be employed. The Title V CSHNP has been addressing these barriers through providing general transition information to families receiving CSHNP/clinic services or attending transition-related community events, and leading/participating in planning Transition Fairs. The next phase is CSHNP working to improve its direct services with youth/families related to transition to adult health care, using an evidence-informed quality improvement approach.<br><br>The Six Core Elements of Health Care Transition is an evidence-informed model for transitioning youth to adult health care providers that has been developed and tested in various clinical and health plan settings. They were developed by the Got Transition/Center for Health Care Transition Improvement, based on the joint clinical recommendations from the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), and American College of Physicians (ACP). References: Got Transition, “Side-By-Side Version, Six Core Elements of Health Care Transition 2.0”; AAP, AAFP, ACP, “Clinical</td></tr>
</table>

Report – Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home", Pediatrics 2011;128:182-200; McPheeters M et al., "Transition Care for Children With Special Health Needs", Technical Brief No. 15. Agency for Healthcare Research and Quality (AHRQ) Publication No. 14-EHC027-EF, June 2014.

**ESM 13.1 - The establishment of leadership for the State Oral Health Program under the direction of a dental professional and staff with public health skills.**
**NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year**

| | |
|---|---|
| **Goal:** | Develop a state oral health program to improve the health of Hawaii families. |
| **Definition:** | **Numerator:** n/a<br>**Denominator:** n/a<br>**Unit Type:** Text<br>**Unit Number:** Yes/No |
| **Data Sources and Data Issues:** | The Data Collection Form lists 6 strategies:<br><br>1. Recruit for Dental Director<br>2. Formal interview of candidates for Dental Director<br>3. Hire and orient Dental Director<br>4. Recruit for Program Specialist<br>5. Formal interview of candidates for Program Specialist<br>6. Hire and orient Program Specialist<br><br>The measure will be answer “Yes” when all six steps are completed.<br>No data issues are anticipated. |
| **Significance:** | For children and pregnant women, regular dental visits allow for the provision of preventive services and the detection of oral disease at an early stage. Unfortunately, only 71% of low-income children and 41% of pregnant women in Hawaii reported seeing a dentist during their pregnancy. This disparity in dental access and utilization highlights the importance of looking at measures to improve the oral health of families throughout the state.<br>To make a measurable difference in the oral health of all Hawaii’s residents (children, pregnant women and families) the State Health department is rebuilding the oral health program (eliminated in 2009). Key to this effort is assuring the program has qualified leadership - a dental professional and staff with public health skills. Significant barriers have made hiring challenging with no dental school in Hawaii, restrictive licensing requirements, and Hawaii’s high cost of living.<br>Clinically trained dental professionals often lack public health training/background to fulfill the duties and responsibilities to prevent and reduce oral disease and address disparities at a population based level. These duties include:<br>•Develop oral health data surveillance through collection and interpretation of data to inform, prioritize, deliver, and monitor oral health programs and population health and share data collection and measurement of results to ensure alignment of efforts and program accountability;<br>•Promote evidence based interventions to reduce the prevalence of oral health disease and eliminate disparities;<br>•Set a common agenda among stakeholders by developing plans for state oral health programs and activities that assure mutual objectives and create common priorities, and<br>•Support mutually reinforcing activities among coalitions and strategic partners implementing |

| | |
|---|---|
| | oral health programs by assessing facilitators and barriers to advancing oral health and implementing communication activities to promote oral disease prevention |

**ESM 13.2 - Completion of teledentistry pilot project at three early childhood settings to reach underserved children and pregnant women.**
**NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year**

| | |
|---|---|
| **Goal:** | Demonstrate the feasibility and effectiveness of teledentistry to improve the oral health of children and pregnant women. |
| **Definition:** | **Numerator:** n/a<br>**Denominator:** n/a<br>**Unit Type:** Text<br>**Unit Number:** Yes/No |
| **Data Sources and Data Issues:** | The process to complete year one of the 3-year project involves several key steps:<br><br>1. Demonstrate need for project and barriers/facilitators that exist<br>2. Educate and inform community oral health stakeholders and others about the teledentistry delivery of care system and applications to Hawaii<br>3. Develop planning committee for teledentistry projects<br>4. Develop proof of concept for teledentistry projects<br>5. Secure funding for three year pilot project<br>6. Develop program orientation for community partners, providers, and site staff to introduce concept<br>7. Identify locations and execute Memorandum of Understanding with three pilot sites<br>8. Develop program protocols and policies and procedures for both dental services and case management<br>9. Develop consents and other communications to parents<br>10. Purchase dental equipment and computer software<br>11. Provide necessary training for providers and site staff<br>12. Develop evaluation plan including economic feasibility analysis<br>13. Teledentistry operational at three sites<br>14. Conduct evaluation and program improvement<br>15. Provide adequate case management to ensure participants establish a dental home<br>16. Inform public of project results, lessons learned, and future considerations<br><br>The measure will be answer “Yes” when all 16 activities are completed. The Department of Health Teledentistry Planning Committee will determine the data for this measure.<br>No data issues are anticipated. |
| **Significance:** | For children and adults, regular dental visits allow for the provision of preventive services and the detection of oral disease at an early stage. Unfortunately, only 71% of low-income children and 52% of low-income adults saw a dentist during the past year. Medicaid enrolled children in Hawaii continue to lag behind in cost-effective preventive measures, such as dental sealant placement.<br><br>Oral health care during pregnancy can be done safely and effectively at all stages of pregnancy, however only 41% of pregnant women in Hawaii reported seeing a dentist during their pregnancy. Disparities remain by county, educational status, low-income and Medicaid |

insured.

These documented oral health needs highlights the importance of improving accessibility to diagnostic and preventive measures to improve the oral health of Hawaii children and pregnant women. Teledentistry can provide diagnostic and preventive dental services for underserved populations that traditionally delay care until they have advanced disease, pain, and infection. Preventive services may be more readily available when provided by hygienists in a public health setting. Dentists are not required to leave the clinic setting but through ‘store and forward’ technology, have the ability to diagnose on their own time, while not delaying the timely preventive interventions that can be provided by hygienists at lower cost. With radiographs and photographs, dentists are able to diagnose conditions remotely while patients receive preventive services in a timely manner. Diagnosis through teledentistry allows for referral of patients in a timely manner and reduces the costs associated with the “high cost dental suite.”

A Hawaii Dental Services Foundation grant has allowed the Department of Heath to begin a one year pilot teledentistry demonstration project. The Hawaii Department of Health Hospital and Community Dental Services Branch has partnered with the Pacific Center for Special Care are the lead for the proje

**Form 10d**
**National Performance Measures (NPMs) (Reporting Year 2014 & 2015)**

**State: Hawaii**

### Form Notes for Form 10d NPMs and SPMs

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.

### 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 | 100.0 |
| Numerator | 15 | 22 | 13 | 27 | 27 |
| Denominator | 15 | 22 | 13 | 27 | 27 |
| Data Source | Hawaii NMSP | Hawaii NMSP | Hawaii NMSP | Hawaii NMSP | Hawaii NMSP |
| Provisional Or Final ? | | | | Final | Provisional |

### Field Level Notes for Form 10d NPMs:

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>Numerator and denominator data are from the State Newborn Metabolic Screening Program. The State of Hawaii test for 32 disorders.<br><br>The annual performance objective for the year 2015 was met. | |
| 2. | **Field Name:** | **2014** |

| | | |
|---|---|---|
| | **Field Note:**<br>Numerator and denominator data are from the State Newborn Metabolic Screening Program. The State of Hawaii test for 32 disorders.<br><br>The annual performance objective for the year 2015 was unchanged. | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:**<br>Numerator and denominator data are from the State Newborn Metabolic Screening Program. The State of Hawaii tests for 32 disorders. | |
| 4. | **Field Name:** | **2012** |
| | **Field Note:**<br>Data are from the State Newborn Metabolic Screening Program, Department of Health. The State of Hawaii tests for 32 disorders. | |
| 5. | **Field Name:** | **2011** |
| | **Field Note:**<br>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 | 77.6 |
| Numerator | 26,502 | 26,502 | 26,502 | 26,502 | 26,502 |
| Denominator | 34,131 | 34,131 | 34,131 | 34,131 | 34,131 |
| Data Source | National CSHCN survey | National CSHCN survey | National CSHCN survey | National CSHCN survey | National CSHCN survey |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**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.

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 for 2015 was not met based on available data.

2. **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.

3. **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.

4. **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.

5. **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 | 45.4 |
| Numerator | 15,157 | 15,157 | 15,157 | 15,157 | 15,157 |
| Denominator | 33,383 | 33,383 | 33,383 | 33,383 | 33,383 |
| Data Source | National CSHCN survey | National CSHCN survey | National CSHCN survey | National CSHCN survey | National CSHCN survey |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**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.

The annual performance objective for 2015 was not met based on available data.

2. **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.

3. **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.

4. **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.

5. **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 | 72.6 |
| Numerator | 24,800 | 24,800 | 24,800 | 24,800 | 24,800 |
| Denominator | 34,158 | 34,158 | 34,158 | 34,158 | 34,158 |
| Data Source | National CSHCN survey | National CSHCN survey | National CSHCN survey | National CSHCN survey | National CSHCN survey |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**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.

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 for 2015 was not met based on available data.

2. **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.

3. **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.

4. **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.

5. **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 | 71.5 |
| Numerator | 24,616 | 24,616 | 24,616 | 24,616 | 24,616 |
| Denominator | 34,430 | 34,430 | 34,430 | 34,430 | 34,430 |
| Data Source | National CSHCN survey | National CSHCN survey | National CSHCN survey | National CSHCN survey | National CSHCN survey |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**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.

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 for 2015 was not met based on available data.

2. **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.

3. **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.

4. **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.

5. **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 | 37.3 |
| Numerator | 4,714 | 4,714 | 4,714 | 4,714 | 4,714 |
| Denominator | 12,643 | 12,643 | 12,643 | 12,643 | 12,643 |
| Data Source | National CSHCN survey | National CSHCN survey | National CSHCN survey | National CSHCN survey | National CSHCN survey |
| Provisional Or Final ? | | | | Final | Final |

### Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

**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.
The annual performance objective for the years 2013 to 2017 was carried forward from 2012 since no new data was available. The annual objective for 2015 was not met based on available data.

2. **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.

3. **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.

4. **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.

5. **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 | 77.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | National Immunization Survey | National Immunization Survey | National Immunization Survey | National Immunization Survey | National Immunization Survey |
| Provisional Or Final ? | | | | Provisional | Provisional |

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**Field Note:**
The estimate for 2014 or 2015 was not available at time of this report from the National Immunization Survey State Data Tables so the 2013 final estimate was carried forward.

The annual performance objective for 2015 was not met based on available data.

2. **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.

3. **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.

4. **Field Name:** **2012**

| | | |
|---|---|---|
| | **Field Note:**<br>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. | |
| 5. | **Field Name:** | **2011** |
| | **Field Note:**<br>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 | 9.7 | 9.7 |
| Numerator | 297 | 283 | 246 | 228 | 228 |
| Denominator | 24,703 | 23,966 | 23,681 | 23,518 | 23,518 |
| Data Source | Hawaii State Vital records | Hawaii State Vital records | Hawaii State Vital records | Hawaii State Vital records | Hawaii State Vital Records |
| Provisional Or Final ? | | | | Provisional | Provisional |

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**Field Note:**
Numerator: Data is from the Office of Health Status Monitoring and is based on resident population by calendar year. Data for the 2014 year was revised with an updated birth data file, while data for the 2015 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, 2014”, filtered for the State of Hawaii. Estimates for the 2015 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 2015 was met based on available data.

2. **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.

Updated with 2014 intercensal estimates

| | | |
|---|---|---|
| 3. | **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.

| | | |
|---|---|---|
| 4. | **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.

| | | |
|---|---|---|
| 5. | **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 | 12.8 |
| Numerator | 3,461 | 3,507 | 3,718 | 3,846 | 4,147 |
| Denominator | 29,852 | 32,204 | 32,491 | 32,615 | 32,281 |
| Data Source | EPSDT CMS-416 | EPSDT CMS-416 | EPSDT CMS-416 | EPSDT CMS-416 | EPSDT CMS-416 |
| Provisional Or Final ? | | | | Final | Provisional |

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**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 not updated

Source for 2015 indicator was from CMS416 form on CMS website (previous years obtained information directly from DHS/Medicaid and was slightly different from what appears on the CMS website).

The annual performance objective for 2015 was met based on available data.

2. **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.

3. **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.

4. **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.

5. **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 | 1.7 |
| Numerator | 12 | 10 | 11 | 13 | 13 |
| Denominator | 749,565 | 761,363 | 767,546 | 778,560 | 778,560 |
| Data Source | Hawaii State Vital records | Hawaii State Vital records | Hawaii State Vital records | Hawaii State Vital records | Hawaii State Vital Records |
| Provisional Or Final ? | | | | Provisional | Provisional |

### Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

**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 2014 was revised with an updated 2014 death data file, while data for the 2015 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 2015 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 2015 was met based on available data.

2. **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.

3. **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.

4. **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.

5. **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 | 61.5 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | National Immunization Survey | National Immunization Survey | National Immunization Survey | National Immunization Survey | National Immunization Survey |
| Provisional Or Final ? | | | | Final | Provisional |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>Data is from the Centers for Disease Control (CDC), 2014 Breastfeeding Report Card. Data from 2015 Report Card is not available at time of entry.<br><br>Numerators and Denominators are not available.<br><br>The annual performance objective for 2015 was met based on available data. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>Data is from the Centers for Disease Control (CDC), 2014 Breastfeeding Report Card. Numerators and Denominators are not available.<br><br>The annual performance objective for the year 2015 was changed to approximately reflect a 5 percent improvement from the 2014 annual indicator. | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:**<br>Data is from the Centers for Disease Control (CDC), 2013 Breastfeeding Report Card. Numerators and Denominators are not available.<br><br>The annual performance objective for the years 2014 to 2018 was changed to match the Healthy People 2020 objective. | |
| 4. | **Field Name:** | **2012** |

| | | |
|---|---|---|
| | **Field Note:**<br>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.<br><br>The annual performance objective for the years 2013 to 2017 was changed to match the Healthy People 2020 objective. | |
| 5. | **Field Name:** | **2011** |
| | **Field Note:**<br>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 | 99.1 |
| Numerator | 18,632 | 18,606 | 18,716 | 18,203 | 18,142 |
| Denominator | 18,889 | 18,889 | 18,866 | 18,381 | 18,310 |
| Data Source | Hawaii NHSP | Hawaii NHSP | Hawaii NHSP | Hawaii NHSP | Hawaii NHSP |
| Provisional Or Final ? | | | | Final | Provisional |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>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.<br><br>Denominator: The denominator is from vital records of live births minus deaths before screening.<br><br>Data for CY 2014 (Jan-Dec) were updated. Data for CY 2015 (Jan-Dec) are preliminary.<br><br>The annual performance objective for 2015 was met based on available data. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>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.<br><br>Denominator: The denominator is from vital records of live births minus deaths before screening.<br><br>Data for CY 2013 (Jan-Dec) were updated. Data for CY 2014 (Jan-Dec) are preliminary.<br><br>The annual performance objective for the year 2015 was unchanged. | |
| 3. | **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.

| | | |
|---|---|---|
| 4. | **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.

| | | |
|---|---|---|
| 5. | **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 | 3.4 |
| Numerator | 10,980 | 10,463 | 9,335 | 9,335 | 10,354 |
| Denominator | 304,077 | 302,565 | 306,848 | 306,848 | 306,259 |
| Data Source | Hawaii Health Survey | American Community Survey | American Community Survey | American Community Survey | American Community Survey |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>Numerator & Denominator: Data is from the American Community Survey 1-year estimate. Data is for children less than 18 years with no health insurance.<br><br>The annual performance objective for 2015 was not met based on available data. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>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.<br><br>The annual performance objective for the year 2015 was changed to approximately reflect a 5 percent improvement from the 2014 annual indicator. | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:**<br>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.<br><br>The annual performance objective for the years 2014 to 2018 was changed to approximately reflect a 5 percent improvement from the 2013 annual indicator. | |
| 4. | **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.

5. **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 | 17.2 |
| Numerator | 3,844 | 3,037 | 3,653 | 3,480 | 3,049 |
| Denominator | 17,879 | 15,590 | 20,210 | 18,943 | 17,742 |
| Data Source | PedNSS | WIC | WIC | WIC | WIC |
| Provisional Or Final ? | | | | Provisional | Provisional |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>Numerator & Denominator: Data is from the Hawaii Department of Health; Family Health Services Division; Women, Infants and Children Services Branch.<br><br>The annual performance objective for 2015 was met based on available data. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>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.<br><br>The annual performance objective for the year 2015 was unchanged. | |
| 3. | **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.

4. **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.

5. **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 | 4.2 | 4.2 |
| Numerator | 926 | 926 | 926 | | |
| Denominator | 18,410 | 18,410 | 18,410 | | |
| Data Source | Hawaii State Department of Health | Hawaii State Department of Health | Hawaii State Department of Health | PRAMS | PRAMS |
| Provisional Or Final ? | | | | Final | Provisional |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>Data for this measure comes from the Pregnancy Risk Assessment Monitoring System (PRAMS) and reflects data from births that occurred in the specified year.<br>Data for the year 2012 is the latest available from PRAMS Hawaii for women who smoke in the last 3 months of pregnancy.<br><br>The annual performance objective for 2015 was met based on available data. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>Data for this measure comes from the Pregnancy Risk Assessment Monitoring System (PRAMS) and reflects data from births that occurred in the specified year.<br>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.<br><br>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.<br><br>Data revised for 2014 to reflect latest available PRAMS data for births from 2012.<br><br>Objectives not available for edits | |
| 3. | **Field Name:** | **2013** |

| | | |
|---|---|---|
| | **Field Note:**<br>Data for this measure comes from the Pregnancy Risk Assessment Monitoring System (PRAMS) and reflects data from births that occurred in the specified year.<br>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.<br><br>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. | |
| 4. | **Field Name:** | **2012** |
| | **Field Note:**<br>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.<br><br>The annual performance objective for the years 2013 to 2017 was changed to approximately reflect a 5 percent improvement from the 2011 annual indicator. | |
| 5. | **Field Name:** | **2011** |
| | **Field Note:**<br>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 | 8.2 |
| Numerator | 30 | 25 | 22 | 20 | 20 |
| Denominator | 249,437 | 251,051 | 245,750 | 242,514 | 242,568 |
| Data Source | Hawaii State Vital records | Hawaii State Vital records | Hawaii State Vital records | Hawaii State Vital records | Hawaii State Vital Records |
| Provisional Or Final ? | | | | Provisional | Provisional |

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**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 2014 was revised with an updated 2014 death data file, while data for the 2015 year was based on a provisional 2015 death data file.

Denominator: Population data is based on U.S. Census Bureau, Population Estimates Program, via the American FactFinder. Population estimates for 2015 were not available from the Census bureau at the time of this report so the prior year ,2014, estimate was used.

The annual performance objective for 2015 was met based on available data.

2. **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.

| | | |
|---|---|---|
| 3. | **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.

| | | |
|---|---|---|
| 4. | **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.

| | | |
|---|---|---|
| 5. | **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 | 90.5 |
| Numerator | 203 | 213 | 235 | 218 | 218 |
| Denominator | 230 | 227 | 262 | 241 | 241 |
| Data Source | Hawai'i State Vital records | Hawai'i State Vital records | Hawaii State Vital records | Hawaii State Vital records | Hawaii State Vital Records |
| Provisional Or Final ? | | | | Provisional | Provisional |

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**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 from 2014 was carried forward and reflects calculations based on 2014 provisional birth 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 2015 was met based on available data.

2. **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 2013 and 2014 was revised with an updated birth data file. Data for the year 2014 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.

3. **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.

4. **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.

5. **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 | 77.9 | 77.9 |
| Numerator | 15,361 | 15,922 | 15,824 | 13,696 | 13,696 |
| Denominator | 18,911 | 18,920 | 18,916 | 17,578 | 17,578 |
| Data Source | Hawai'i State Vital records | Hawai'i State Vital records | Hawaii State Vital records | Hawaii State Vital records | Hawaii State Vital Records |
| Provisional Or Final ? | | | | Provisional | Provisional |

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**Field Note:**
Numerator & Denominator: Data is from the Office of Health Status Monitoring and is based on resident population by calendar year. Data for 2015 is not available and data updated to reflect National Outcome Measure 1 Federally Available Data.

Not appropriate to compare to data based on birth certificates prior to 2014 due to revision of the Hawaii birth certificate in 2014.

The annual performance objective for 2015 was not met based on available data.

2. **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 2014 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.

Data updated to reflect National Outcome Measure 1

3. **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.

| | | |
|---|---|---|
| 4. | **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.

| | | |
|---|---|---|
| 5. | **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 | 52.0 |
| Numerator | 11,604 | 11,632 | 11,630 | 11,630 | 11,630 |
| Denominator | 22,480 | 22,350 | 22,346 | 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 | Hawaii State Department of Health |
| Provisional Or Final ? | | | | Provisional | Provisional |

### Field Level Notes for Form 10d SPMs:

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>No New Data for 2015. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>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 2014.<br><br>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. | |
| 3. | **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.

4. **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.

5. **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 |
|---|---|---|---|---|---|
| Annual Objective | 4.0 | 6.0 | 6.0 | 6.0 | 6.0 |
| Annual Indicator | 6.9 | 6.9 | 6.9 | 7.9 | 7.9 |
| Numerator | 1,267 | 1,267 | 1,267 | | |
| Denominator | 18,437 | 18,437 | 18,437 | | |
| Data Source | Hawaii State Department of Health | Hawaii State Department of Health | Hawaii PRAMS | Hawaii PRAMS | Hawaii PRAMS |
| Provisional Or Final ? | | | | Provisional | Provisional |

### Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

**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 2012 is the latest available from PRAMS Hawaii.

The 2015 objective was not met based on the latest available data.

No numerator/denominator provider as based on survey data and only rounded population numbers available

2. **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.

Updated to reflect 2012 birth year PRAMS data which is latest available at time of report May 2016. Unable to adjust objectives.

No numerator/denominator provider as based on survey data and only rounded population numbers available

3. **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.

4. **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.

5. **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 | 38.9 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | NSCH Survey | NSCH Survey | NSCH Survey | NSCH Survey | NSCH Survey |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** **2015**

**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 2015 was not met based on the latest available data

2. **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.

3. **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.

4. **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.

5. **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 | 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 | University of Hawaii; Center on the Family |
| Provisional Or Final ? | | | | Final | Provisional |

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** **2015**

**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 2014. Data for 2015 was not available at time of this report so data from 2014 was carried to 2015.

The annual performance objective for the year 2015 was not met based on the latest available data.

No new data for 2015 available.

2. **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.

3. **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.

4. **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..

5. **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.
.

## 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 | 34.5 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | National CSHCN Survey | National CSHCN Survey | National CSHCN Survey | National CSHCN Survey | National CSHCN Survey |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** **2015**

**Field Note:**
For 2011-2015, 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 2011-2015 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 for 2015 was not met based on available data.

2. **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

3. **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.

4. **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.

5. **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 | 70.8 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | YTS | YRBS | YRBS | YRBS |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** **2015**

**Field Note:**
Numerators and denominators are not available.

Data for 2015 comes from the YRBS Oral Health Survey.

The 2015 annual objective was not met.

2. **Field Name:** **2014**

**Field Note:**
Numerators and denominators are not available.

Data for 2014 comes from the 2013 YRBS Oral Health Measure and is not comparable with the 2013 indicator. The 2014 indicator was revised by excluding 8.8% of the 2013 data from YRBS that had missing/unknown information for this indicator.

Due to the revision in the methodology for calculating the 2014 indicator, the annual performance objective for the year 2016 and further was updated.

3. **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.

4. **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 | 20.0 |
| Numerator | | 2,080 | 2,480 | 2,356 | 2,053 |
| Denominator | | 9,237 | 11,676 | 10,997 | 10,270 |
| Data Source | | WIC | WIC | WIC | WIC |
| Provisional Or Final ? | | | | Provisional | Provisional |

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** **2015**

**Field Note:**
Numerator & Denominator: Data is from the Hawaii Department of Health; Family Health Services Division; Women, Infants and Children Services Branch.

The annual performance objective for the year 2015 was met.

2. **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.

3. **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.

| | | |
|---|---|---|
| 4. | **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 current application/annual report.

**State Action Plan Table**

**State: Hawaii**

Please click the link below to download a PDF of the full version of the State Action Plan Table.
State Action Plan Table

## Abbreviated State Action Plan Table

## State: Hawaii

### Women/Maternal Health

| State Priority Needs | NPMs | ESMs | SPMs |
|---|---|---|---|
| Promote reproductive life planning | NPM 1 - Well-Woman Visit | ESM 1.1 | |

### Perinatal/Infant Health

| State Priority Needs | NPMs | ESMs | SPMs |
|---|---|---|---|
| Reduce the rate of infant mortality | NPM 4 - Breastfeeding | ESM 4.1 | |
| Reduce the rate of infant mortality | NPM 5 - Safe Sleep | ESM 5.1 | |

### Child Health

| State Priority Needs | NPMs | ESMs | SPMs |
|---|---|---|---|
| Improve the percentage of children screened early and continuously age 0-5 years for developmental delay | NPM 6 - Developmental Screening | ESM 6.1 | |
| Reduce the rate of child abuse and neglect with special attention on ages 0-5 years. | NPM 7 - Injury Hospitalization | ESM 7.1 | |

### Adolescent Health

| State Priority Needs | NPMs | ESMs | SPMs |
|---|---|---|---|
| Improve the healthy development, health, safety, and well-being of adolescents | NPM 10 - Adolescent Well-Visit | ESM 10.1 | |

### Children with Special Health Care Needs

| State Priority Needs | NPMs | ESMs | SPMs |
|---|---|---|---|
| Improve the percentage of youth with special health care needs ages 14-21 years who receive services necessary to make transitions to adult health care. | NPM 12 - Transition | ESM 12.1 | |

### Cross-Cutting/Life Course

| State Priority Needs | NPMs | ESMs | SPMs |
|---|---|---|---|
| Improve the oral health of children and pregnant women. | NPM 13 - Preventive Dental Visit | ESM 13.1<br>ESM 13.2 | |
| Improve access to services through telehealth | | | SPM 1 |
| Improve family and consumer engagement in Title V Programs. | | | SPM 2 |
| Improve partner engagement in Family Health Services Division (FHSD). | | | SPM 3 |