



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

**State Narrative for
Hawaii**

**Application for 2013
Annual Report for 2011**



Document Generation Date: Monday, September 24, 2012

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Copies of the Title V Assurances and Certifications are available in the Family Health Services Division Office, mailing address:

Family Health Services Division
Hawaii State Department of Health
P.O. Box 3378
Honolulu, HI 96801
Phone: (808) 586-4122
Fax: (808) 586-9303

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 2012; expires January 31, 2015.

E. Public Input

Public input was obtained throughout the past year as part of routine staff presentations and participation in coalitions, advisory boards, conferences, professional and community meetings. Performance measure narratives were developed in consultation with input from collaborating agencies, community advocates, and families.

For a listing of the types of agencies and organizations that provide input into the Title V report see the Section III.E. on State Agency Coordination.

Copies of the Title V Block Grant Report and Application are routinely mailed to 25 agency partners, community representatives, and concerned individuals. Many of these stakeholders are also invited to join the Title V grant review. Copies of the report are also available directly from FHSD upon request by the public. Information on the Title V report and a link to Title V information system is also on the Department of Health (DOH) website.

To garner interest and input for the annual Title grant report, the Title V agency has focused on analyzing and publishing Title V/MCH data in user friendly formats (fact sheets and short databooks) to raise awareness about health issues important to the MCH population. The publications have been an effective method to initiate discussion and solicit information/input for the annual Title V report and 2010 needs assessment. Dr. Don Hayes, the Title V agency's Centers for Disease Control-assigned epidemiologist, provided crucial guidance for the development of these projects. Title V funds are used to pay for Dr. Hayes' salary. The federal State Systems Development Initiative (SSDI grant) has also been utilized to help develop greater

epidemiology capacity and resources for this effort.

In 2008 FHSD completed a compendium of perinatal health fact sheets utilizing data from several Title V measures and indicators. Over 175 copies were distributed at a State Perinatal Summit held in October 2008 where stakeholders were asked for their input to identify state perinatal health priorities for the 2010 Title V needs assessment. An additional 500 copies were printed and were distributed to partner agencies and programs. Based on the feedback from stakeholders, more fact sheets have been developed on additional health topics including intimate partner violence, diabetes during pregnancy and characteristics of women with preconception obesity and its impact on birth outcomes. In July 2010 FHSD will publish an eight-year PRAMS Trend data report.

In August 2008, the Title V agency published a FHSD Profiles Databook in August 2008 that highlights the state Title V priority health issues and performance measures. Data from the key MCH datasets identified in Health Systems Capacity Indicator 9 in this report were used in the publication. The document also includes descriptive data on the MCH population, including some of the Title V Health Status Indicator data. The databook provides a description of programs and activities within the Title V agency that help improve the health outcomes tracked by Title V. Three hundred copies of the report were distributed and the publication is on the DOH website. The report was used to engage stakeholders to provide input to the Title V annual report and needs assessment.

A series of fact sheets are being finalized for each of the state priority health issues identified through the 2010 Title V needs assessment to educate and mobilize stakeholders to participate in the development of action plans and to support implementation. Drafts of the fact sheets have been circulated among key stakeholders for input and have generated thoughtful discussions about data, current resources, and collaborative strategies. All fact sheets will be placed on the DOH website when finalized.

/2012/ FHSD continues to solicit input for the application and NA process throughout the year. Outreach for input was conducted by the MCH staff and through collaborative efforts with the wide range of organizations and agencies described in the report. Copies of specific narratives are often shared with community partners for comment and revision if needed.

The fact sheets on the seven priority issues have been finalized, but are routinely updated with new information and shared with the public and with agency stakeholders as well as advocacy and consumer organizations. In August 2010 Hawaii PRAMS released the 2000-2008 Trend Report as an easy to understand reference guide for the lay population. Later in 2011, PRAMS County Profile reports were completed for each neighbor island county and distributed.

FHSD will be updating the Division Profiles publication that highlights most of the Title V performance measures and program information. The data publications continue to be an effective method to engage stakeholders in dialogue about the key MCH health issues and services needs.//2012//

/2013/ Efforts to solicit input and information from the MCH stakeholders and partners to develop the Title V report and application continue. The FHSD Division Profiles will be released in August 2013. The document presents population based, surveillance, and programmatic data; and highlights efforts by FHSD to address 36 key health indicators for the MCH population (including most of the Title V grant performance measures). The Profiles provides an overview of the broad and diverse efforts FHSD leads or collaborates on to improve MCH health. The Profiles serve as a valuable resource to advocate for MCH programs with policymakers and promote the Governor's focus on early childhood. The document will also be used by the Division for upcoming strategic planning efforts.

FHSD is currently developing of a web page on the DOH website with a separate Title V

page that will provide a link to the Title V annual report for public input, as recommended at the last Title V grant review. The MCHB resource document, "Facilitating Public Comment on the Title V MCH Block Grant" was reviewed and other "noteworthy" state websites identified in the report were examined for layout and content ideas. Also, formal public notices are being considered similar to those used by WIC and for the revision of program administrative rules. //2013//

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

HAWAII MATERNAL CHILD HEALTH PRIORITIES

Seven priority issues were identified through the Title V Maternal and Child Health (MCH) needs assessment (NA) process. These priorities are expected to be the programmatic focus for the Family Health Services Division (FHSD), the state Title V MCH agency, in conjunction with many of our partnering organizations during the next five years (2010-2015). The 7 priorities for the state MCH population are:

1. Reduce the rate of unintended pregnancy
2. Reduce the rate of alcohol use during pregnancy
3. Improve the percentage of children screened early and continuously age 0-5 for developmental delay
4. 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
5. Reduce the rate of child abuse and neglect with special attention on ages 0-5 years
6. Reduce the rate of overweight and obesity in young children ages 0-5
7. Prevent bullying behavior among children with special attention on adolescents age 11-18 years

CHANGES IN POPULATION STRENGTHS AND NEEDS IN THE STATE PRIORITIES

There continued to be significant changes in the population strengths/needs during the interim year 2011. Although most of the health outcome indicators and measures remained relatively stable, those measures directly reflecting the adverse economic impact of the recession on the MCH population continued to worsen in 2011. The indicator which clearly captured this impact is HSI 9 which showed increases in virtually all entitlement programs for the low-income children: WIC, Medicaid, Food Stamps.

Also estimates comparing perinatal indicators (HSCI 5a-d) continued to show worse outcomes and service utilization among those that are in Medicaid. Many of these women and their children are likely to also be participating in food stamps and WIC programs due to similar eligibility requirements. Efforts to partner with Medicaid providers, particularly Community Health Centers to improve birth and early childhood outcomes among this population are being pursued and are an important area of concern for the Department. Some of the initiatives include a Prenatal Summit to be held in August 2012 and funding for CenteringPregnancy training of perinatal providers that work with high-risk populations. Medicaid partnerships will also focus on expanding EPSDT data collection, improving children's oral health, and obesity prevention.

CHANGES IN THE STATE MCH PROGRAM OR SYSTEM CAPACITY

Since the last Title V application, MCH staffing capacity to address bullying prevention has been compromised somewhat. In an effort to maximize federal funding opportunities for the state, MCH Branch staff has been dedicated to grant-writing and administering federal grants for teen pregnancy prevention, abstinence education, and the Maternal Infant Early Childhood Home Visitation (MIECHV). Moreover, community bullying prevention initiatives on the neighbor islands have been comprised in 2012 with vacancies in two Title V-funded MCH nurse positions which will not be filled due to limited Title V funding.

ACTIVITIES TO OPERATIONALIZE THE 5-YEAR NEEDS ASSESSMENT

Issue workgroups have been formed for each priority and are led by one or more Title V program

staff. Problem analysis was conducted for each issue and problem maps were completed based on literature reviews, data, and other expert consultation. To identify strategies, the Issue groups continue to conduct resource assessments and network with stakeholders to develop feasible strategies given the challenging economic climate.

Based on the problem analysis and review of data, fact sheets have been developed for each of the 7 priorities issues. The fact sheet are regularly updated with new data and information. The fact sheets have been instrumental in engaging stakeholders and initiating discussion around the issues and identifying strategies/actions. They are routinely used in presentations, coalition and advisory group meetings, and discussions with policymakers.

With limited resources, the issue workgroups have not developed formal action plans, but have focused efforts on seeking out key collaborative opportunities to partner around specific projects or integrating the priority issues into existing program or policy efforts. These partnerships and opportunities have taken some time to develop and pursue. For example, the Prenatal Alcohol workgroup is now integrated as a sub-committee of the State Fetal Alcohol Spectrum Task Force. The child obesity workgroup, which is focusing on the early childhood period, is collaborating with Department of Health and Administrative Initiatives to combat obesity.

Early developmental screening has been integrated into the Governor's Office sponsored "Collective Impact" process which is convening public-private partners to address key social issues for the homelessness, elderly, at-risk and foster youth, working poor, and early childhood. In 2011, the Early Childhood (EC) Group chose to focus on developmental screening in partnership with the DOH.

The workgroup on Transition to Adult Healthcare for Youth with Special Health Needs (YSHN) is collaborating on the neighbor islands with the Department of Education (DOE), Developmental Disabilities, Vocational Rehab, and Children's Councils to promote transition planning education and support for YSHN and their families. The neighbor island transition collaborations have now been captured in state DOE reports as a model for other school districts. The child abuse and neglect workgroup have integrated their efforts as part of the Hawai'i Children's Trust Fund, established by state statute to support family strengthening programs aimed at preventing CAN. See state performance measure narratives for more details.

Where possible Title V is including the state priorities into policy/planning documents such as the 2012 DOH Strategic Plan and the development of a state Early Childhood Plan. The priorities will be an important focus for future Division strategic planning efforts.

Issue workgroup leaders report on progress to the Division Senior management annually and also provide updates/solicit input at an annual Division/MCH Partnership meeting.

To support the needs assessment work several data publications have been developed. The reports also serve as routine surveillance documents to monitor the health for the MCH population. The leadership and efforts of the CDC-assigned MCH Epidemiologist and resources from the State Systems Development Initiative (SSDI) grant have been essential to support the achievements in this area. The publications include: A Compendium of Perinatal Fact Sheets, Family Health Services Division Profiles, Primary Care Needs Assessment Databook, PRAMS Eight Year Trends Report, PRAMS County Profiles, and the Hawaii Children's Health Disparities report. The 2012 Family Health Services Division Profiles and Primary Care Needs Assessment Databook will be released in August 2012.

CURRENT UPDATES/NEXT STEPS

SSDI funds were used to host a MCH partnership meeting was held in October 2011 to highlight progress on the priority issues, provide an overview of MCH data and showcase several FHSD examples of using data to inform program and policy decisions. Many Division staff and key MCH stakeholders were in attendance. Breakout groups on each of the state priorities reviewed data

and focused on identifying partnership opportunities and collaborative activities for each issue.

FHSD continues to compile and analyze data for use by the Issue workgroups. As a result of the breakout groups at the annual partnership meeting, several of the issues found their current data sources were insufficient to provide a good assessment on disparities including data from the National Survey on Child Health (developmental screening), YRBS (bullying prevention), the National Survey on Children with Special Health Needs (Transition to Adult Care) and Child Obesity (WIC PedNSS). The workgroups have identified data strategies/activities to examine new or alternative data sources to address the limitations.

Work groups for the seven priority issues continue to meet and partner with agency stakeholders to identify collaborative strategies and identify resource opportunities to address the state MCH health issues. Activities include conducting presentations at conferences/forums, local radio shows, and brown-bag meetings; sharing information at health fairs; developing education resources for consumers; and working with partners on collaborative strategies.

Again, many of the Issue groups were active during this year's legislative session. Bills addressing bullying and providing funding for developmental screening, perinatal services, child obesity, home visiting/CAN prevention were introduced. Most of the legislation failed to pass this year, but many of the bills received full hearings and helped focus public attention on these key health issues. The Issue groups assisted with legislative monitoring, educating partners, and mobilizing support.

The FHSD Senior management will have the leaders from the 7 Issue groups report on their progress to date. The meetings allow FHSD senior staff to understand challenges and assist with possible resolutions (i.e. establishing new partnerships within and across state departments, provide insight on policy initiatives, provide direction on identifying feasible/workable strategies). FHSD will be planning its annual Division/MCH Partnership meeting to present progress on priority issues and continue to identify collaborative opportunities with MCH stakeholders.

III. State Overview

A. Overview

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. Six time zones separate Hawaii from the eastern U.S. This means 9 am (eastern standard time) in Washington, D.C. is 6 am in Los Angeles and 4 am in Hawaii.

The State is composed of 7 populated islands located in 4 major counties: Hawaii, Maui, O'ahu, and Kaua'i (see attached Figure 1). 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.

Approximately 70% of the state population resides in the City and County of Honolulu on the island of O'ahu, concentrated in the Honolulu metropolitan area. The neighbor island counties are Hawaii, Kaua'i (includes Ni'ihau) and Maui (includes Moloka'i, Lana'i, and Kaho'olawe, 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 are located on O'ahu. 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 all areas of the state except for the city of Honolulu. Residents in rural communities, especially on the neighbor islands, need an automobile 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.

/2012/ There has been some progress with the addition of public transportation with bus routes on the islands of Maui, Kauai, and Hawaii, but their use is sporadic and limited.//2012//

DEMOGRAPHICS

According the 2008 Census estimates, 1.3 million residents live in Hawaii. The state's population continues to slowly shift away from urban Honolulu. O'ahu is still where nearly three-fourths of the state's population lives (905,034 residents), but its share of residents is slowly declining: from 72.3% in 2000 to 70.3% in 2008. Population growth is largely occurring on the neighbor islands. Over 13% of Hawaii's people were estimated to be living on the Big Island (175,784 residents) in 2008, 11.2% (143,691 residents) in Maui County, and almost 4.9% (63,689) on Kauai.

/2012/ According the 2010 Census, 1.4 million residents live in Hawaii. The state's population continues to slowly shift away from urban Honolulu with population growth largely occurring on the neighbor islands. Oahu is still where nearly three-fourths (70.1%) of the state's population lives (953,207 residents), while 13.6% live on the Big Island (185,079 residents), 11.4% (154,834 residents) in Maui County, and 4.9% (67,091) in Kauai County. Since 2000, there has been an overall growth in the state of 12.3% (2010 Census data). The growth has primarily been on the neighbor islands with 24.5% on the island of Hawaii, 22.8% on the island of Maui, 14.8% on the island of Kauai, 8.8% on the island of Oahu, and 6.3% on the island of Niihau. There were small

declines on the islands of Molokai (-0.8%) and Lanai (-1.8%).//2012//

Hawaii's population, like the U.S. as a whole is aging. The median age of Hawaii residents increased from 36.2 to 38.0 over the last decade, higher than the national average of 36.7. Between 2000 and 2008 there were increases in the proportion in those 20-34, 55-74, and 75 years and older, while the proportion of children and youth age 0-19 years and younger adults 35-54 years decreased. The largest increase was among the elderly, those 75 years and older, representing a 33% increase since 2000, followed by a 26% increase among those 55-74 years of age.

//2012/ Hawaii's population, like the U.S. as a whole is aging. The median age of Hawaii residents increased from 36.2 to 38.6 over the last decade, higher than the national average of 37.2 in 2010. The largest increase was among those 60-64 years of age, representing a 58% increase since 2000, followed by a 57% increase among those 85 years and older, and 38% increase among those 55-59 years of age.//2012//

ETHNIC DIVERSITY

Unlike most of the United States, the ethnic composition of the state's population is very heterogeneous and no single ethnic majority emerges. Caucasian, Japanese, Filipino, and Part-Hawaiian are the largest ethnic groups and their proportions differ by county. These four ethnic groups combined represent about 74% of the state's population according to the 2008 Census estimates. Some 18.6% of the people in Hawaii indicate they are of two or more races.

//2012/ The 2010 census data highlights that 23.6% of the population report more than one race and 76.4% report only one single race. In terms of total population count, calculated as the percent of the total population, Asians (525,078 residents) accounted for 38.6% of the population, Whites (336,599) accounted for 24.7%, and Native Hawaiian or Other Pacific Islander (135,422) accounted for 10.0%, and those with two or more races accounted for 23.6%. The largest groups within the single race Asians were Filipino (197,497), Japanese (185,502), and Chinese (54,955). //2012//

Hawaii is considered a gateway to the U.S. for immigrants from Asia and the Pacific. According to U.S. Census and the Immigration and Naturalization Service, 17.8% of Hawaii's population is foreign-born, the 6th highest percentage according to the 2008 Census. Nearly 35,000 immigrants were legally admitted to the state between 2005 and 2009 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.

Because of this ethnic diversity, there are a number of people who speak English as a second language. In 2008, approximately 7.8% (13,791) of the state's public elementary school children were enrolled in the Students with Limited English Proficiency Program. According to the Governor's Council on Literacy, over 155,000 adults or an estimated 16% of Hawaii's adults are functionally illiterate. The 2008 Census reports that 254,172 people in Hawaii speak a language in the home other than English.

Other sub-populations within the state include U.S. Armed Forces personnel and their dependents which comprise an estimated 6.8% of the state population (110,713 people).

ECONOMY

//2013/ Hawaii's economy showed signs of stabilization and slow recovery in 2011. Hawaii's tourism industry, the state's economic engine, saw its highest growth in tourists and spending in four years. Many retailers reported the best holiday season sales for in three years. Overall, personal income and the state's jobless rate remained unchanged. //2013//

Unemployment and the recession is the primary concern for Hawaii. In 2007 Hawaii had one of the lowest unemployment rates (2.3%) in the nation; by 2009 Hawaii's unemployment rates increased to 7.4% with a record 47,000 individuals unemployed. Hawaii is still reporting one of

the lowest unemployment rates in the nation. Hawaii with a current unemployment rate of 6.7% compares favorably to the seasonally adjusted national unemployment rate of 9.9%.

The lowering of the unemployment rate in several years is encouraging. However, the unemployment rates across the islands are quite variable: Oahu 5.2%, Lanai 6%, Maui, 8.3%; Kauai 8.9%, Hawaii 9.5% and Molokai 11.8%. The job market was influenced by the addition of 1,600 jobs as a result of federal stimulus funds. Regardless, there are still 42,569 individuals reported as unemployed; and 8% of Hawaii workers report they work multiple jobs to make ends meet.

/2012/In 2011, the rate has decreased somewhat with an estimated 6.3% of the state population unemployed and below the national rate of 9.8%. Unemployment rates across counties are variable: Honolulu 5.4%; Maui, 7.9%; Kauai 8.5%; and Hawaii 9.3% (Jan 2011 not-seasonally adjusted).//2012//

/2013/ According to the Bureau of Labor Statistics Current Population Survey (CPS), the unemployment rate for Hawaii was 6.3% in May 2012. The state unemployment rate was 1.9 percentage points lower than the national rate for the month (8.2%). The unemployment rate in Hawaii peaked in June 2009 at 7.1% and is now 0.8 percentage points lower. //2013//

Given recent performance, the Hawaii economy is projected to show a 1.1% growth in 2010; and expected to increase modestly to 1.4% in 2011.

/2013/ The state's economy is projected to expand to 2.2% in 2012 and will continue to grow by 2.3% in 2013. //2013//

Hawaii's poverty rate in 2008 was 9.1% compared to 8% in 2007. More than 115,000 residents live in poverty. Hawaii's homeless rate rose from 10-15%: 3,350 were in shelters and 2,600 were unsheltered. Over 37,000 or 11.6% of children in Hawaii live in households below the federal poverty level. In 2007, 36.2% were living in households at 200-399% FPL.

/2012/ Hawaii's poverty rate in 2009 was 10.4% (all ages in poverty). This represents an estimated 132,000 individuals living in poverty in the state. This represents that over 39,000 or 13.7% of those under 18 years of age live in households below the federal poverty level. Like unemployment rates, poverty rates are variable across counties: Honolulu 9.7%; Maui, 10.2%; Kauai 10.4%; and Hawaii 14.5%.

An estimated 5,782 (3,268 sheltered and 2,514 unsheltered) individuals were homeless for a rate in the population of 0.45% which is more than double the national estimated rate of 0.21% (Jan 2009, 2009 Annual Homeless Assessment). These numbers likely underestimate the true burden of homelessness in the State.//2012//

/2013/ From July 1, 2010 to June 30, 2011, state Shelter and Outreach Programs served a total of 14,200 individuals statewide. This number represents an unduplicated count of individuals who experienced homelessness and received shelter and/or outreach services during the 2011 fiscal year. After several years of sharp increases, the total number of clients served by these programs dropped slightly, by 3%, between 2010 and 2011. New reporting methodology and increased utilization of the state's Homeless Management Information System, a centralized electronic data system on homeless persons, account for the substantial increase from previous numbers reported. Numbers for homeless in the state are underestimates. //2013//

Bankruptcy filing in April 2010 were up 56% from 2009 (391), this is the highest level in four and half years. Bankruptcies have risen for three consecutive months as people continue to experience economic problems due to unemployment or fewer hours worked.

/2013/ Bankruptcy filings in Hawaii fell in June 2012 for the 16th consecutive month, according to data from the U.S. Bankruptcy Court. The number of cases filed in June was 33% fewer than the same month a year earlier. The volume of filings in June was the lowest in nearly four years. Bankruptcy filings have been trending lower since hitting a peak in 2010. //2013//

GOVERNMENT

Faced with a \$1.2B deficit for the biennium (out of a \$10B budget) the Governor's response was to cut services to the public by restricting government contracts for health and human services by 14%; instituting 2 day a month mandated furloughs, and to cut more than 800 state funded government positions equating to a 1% reduction in government workforce. Some government agencies were more greatly affected than others; however the overall net effect was less service provision for the general public and vulnerable populations.

/2012/ Two-day furloughs were eliminated in State fiscal year 2012; however, there was a 5% reduction in compensation for all positions in fiscal year 2012 year to keep government offices open and providing services to the general public. A hiring freeze is in effect for state and special funded positions. The newly elected Administration is exploring governmental restructuring, including the possible elimination of entire programs and departments.//2012//

The May 2010 State Council on Revenues reported some indication of the economy slowly rebounding with a prediction that FY 2010 will end with a 0.5% increase in tax revenues; in March the Council predicted a 2.5% decline in revenues. The Council now projects a 6% increase in revenues for FY 2011.

/2012/In May 2011 the Council on Revenues held Hawaii's projected growth at a negative 1.6%.//2012//

/2013/ Amid strong tourism numbers, the State Council on Revenues projected revenue growth for 2013 to be 5.3% in March 2012. //2013//

TOURISM

Hawaii's economy is largely driven by the tourism, real estate and construction sectors. The current national recession has severely impacted Hawaii's primary economic driver, tourism; although the State is beginning to witness some encouraging signs of recovery. According to the Department of Business, Economic Development and Tourism (DBEDT), visitor arrivals are expected to increase 2.6% in 2010 and 4.1% in 2011. This modest increase is welcomed after experiencing a 10.6% reduction in 2008 and an additional 4.5% in 2009 in visitor arrivals. Hotel occupancy rates are beginning to see a modest increase due to marketing reduced hotel rates to encourage visitors. Hawaii is expected to see 6.7M visitor arrivals for 2010.

Hotel occupancy rate for February 2010 was 73.5% full as compared to 72.5% in 2009. The improvement in hotel occupancy comes at a price for hotel owners who have slashed room rates over the past several years to attract guests. The average daily room rate fell to \$175 compared to \$188 in 2009. Again the hotel occupancy rates varied by county: Oahu 80.5%, Maui 77.9%, Kauai 62.8%, Hawaii 62.4%.

/2012/ Despite the negative impact of the March 2011 Tohoku Earthquake and tsunami on Japanese travel to Hawaii, DBEDT projects that overall visitor arrivals will increase by 3.8% for 2011, a rate similar to its previous forecast conducted before the Japan earthquake. While hotel occupancy was up 8.7% in 2010, deep rate discounts meant decreased room revenues for the year. //2012//

/2013/ The tourism sector rebounded in 2011 as anticipated with increases in both visitor arrivals and spending. The 2011 state visitor count was up almost 4% over 2010, nearly 7.3 million visitors. Vacationers spent \$12.58 billion in 2011, a 15.6% increase over 2010 and the second-highest total in state history, according to the Hawaii Tourism Authority. Occupancy levels at Hawaii hotels surged from a low of 67% in March 2009 to 77% during January 2012, according to Smith Travel Research. Average room rates during that period rose from \$182 in 2009 to \$238 in January 2012.//2013//

CONSTRUCTION

In September 2009, residential building permits were projected to fall 44% and it has pushed back by a year its forecast for a surge in federal and state infrastructure spending. Year-to-date nonresidential construction permits, valued at \$811 million, were 24% lower than the same time last year.

/2013/ The one weak sector of the State economy remains the construction industry. Significant declines continued to occur in permitting for residential and commercial construction. The value of statewide residential permits fell more than 13% in 2011, to the lowest level on record. Forecasters anticipate major investments in public works projects, including Rail transit, and several large new commercial projects may improve outcomes for this sector in the coming year. //2013//

HIGH COST OF LIVING

While Hawaii has seen some reduction in the cost for single family homes and condominiums, housing costs are still substantially higher than the national average. The median housing cost is \$563,000 for a single family dwelling and \$388,000 for a condominium. In October 2009, RealtyTrac ranked Hawaii 17th among states for foreclosures. Foreclosures in Hawaii grew more than 134% from the prior year.

/2012/ The number of foreclosures rose 11% in 2010 compared to 2009. //2012//

/2013/ Although the number of foreclosures dropped by 52% from 2010, this was due largely to the passage of a new state foreclosure law as provisions of the new law are implemented.//2013//

Hawaii was listed for the fifth straight year as having the least affordable rental units in the Nation. An estimated 44% of Hawaii residents rent; an average monthly rate for a two bedroom is about \$500-\$2,000 and \$900-\$1,000 for a studio. This often leads to more than one family living within the same dwelling.

While many in Hawaii have witnessed either a cut in salary or reduction in hours worked; other costs in the community continue to rise. Gasoline prices have risen to an average of \$3.55 per gallon, with cost over \$4 on the neighbor islands. Higher crude oil rates translate into increased cost not only for personal ground transportation, but rate increases for electricity and other consumables that must be imported to Hawaii. Service/User fees for county level services have also increased.

/2013/ Like the rest of the U.S. Hawaii gas prices have increased since last year, but have been stabilizing. In June 2012 the state average gas price was \$4.21, 18 cents more than a year ago. //2013//

The Hawaii General Excise Tax is currently 4% statewide. Oahu has an additional 1/2% surcharge imposed to fund rail mass transit. All goods and services on Oahu, including the City and County of Honolulu are taxed at 4 1/2% of gross sales. This GET is assessed on the provider of the goods and services and in turn passes the cost on to the consumer at a rate of 4.712% on Oahu and approximately 4.2% on Neighbor Islands. During the past three decades, Hawaii has consistently had one of the nation's highest tax burdens. Estimated at 10.6% of income, compared to the national average of 9.7%, Hawaii ranked 5th highest for its state/local tax burden.

Health Insurance premiums have risen on average 10% each year for the past three years. This has placed additional burdens on small business and government employees who were required to absorb all increases.

POLITICAL CONTEXT

Governor Lingle submitted her last Biennium Executive Budget to the Hawaii State Legislature. She will be completing her eighth year in office in December 2010. The 2010 legislative session was the most acrimonious in decades because of the severe budget shortfall and political differences over strategies to address the projected \$1.2B deficit. The Governor's approach was conservative: cut government spending, services and staffing. Health and Human Services providers expressed concern that the budget was being balanced on the neediest, with cuts to benefits and services. Government employees and unions expressed concern that the budget was being balanced on the backs of staff with reduction in force, furloughs and pay cuts. Health and Human Services contractors were outraged to learn that the last quarter billings of fiscal year

2010 may not be paid until the first quarter of fiscal year 2011; effectively a three month delay in payment. A huge controversy arose over the furloughing of teachers twice a month, resulting in Hawaii having the lowest number of school days in the nation.

The Hawaii State Legislature chose to utilize the Hawaii Emergency and Relief Fund (Rainy Day set asides from a portion of the State's Master Settlement Tobacco Fund) and the Hurricane Relief Fund to reinstate teacher furlough days and funding for essential health and human services. This included funds for Healthy Start Home Visiting Program, Respite and Community Health Centers. However, the actual release and expenditure of these funds will depend upon the Governor's signage of the bills. At this point it is anticipated that the Governor will veto the budget proposed by the Legislature.

Balancing the State's budget and the restoration of services was the central issue occupying 90% of the legislative agenda. The most controversial issues were school furloughs, the Honolulu Rail Transit project and equal benefits for same sex partners.

The Legislature has set aside \$67M of the Hurricane Relief Fund to restore 18 furlough days for the 2010-11 school year. Governor Lingle has offered \$57 M to restore the majority of the furlough days for "essential" staff and suggested that the teachers voluntarily restore other days. The resolution of this issue has been negotiated between the Governor, the Board of Education, Department of Education and the Hawaii State Teachers Association. The agreement reached includes the restoration of 18 furlough days with the \$57M from the Hurricane Fund, teachers agreeing to use 6 planning days as instructional days, and a zero percent credit line for \$10M. The credit line cannot be used for salaries, only operating expenses. Governor Lingle has also advocated for the decentralization of Hawaii's singular school and one school board system, and has opposed having an elected school board. The Hawaii State Legislature passed legislation to place the question of school board selection on the election ballot this Fall.

The State Legislature considered the redirecting of the Honolulu Transit Tax to balance the state budget. While this did not occur, the Governor and Mayor have been at odds over the release of the Environmental Impact Statement, the feasibility and cost of the rail which will be the largest public works project in the history of the state; thus jeopardizing the timely release of federal funds.

Hawaii as many other states is entering the campaign season. The election will radically change the State's political landscape in 2011 with the election of a new Governor, Lt. Governor, Congressional Delegate (one of only four seats), and virtually a new legislative body as many current members have reached term limits. The election of a new Governor will bring the appointment of a new cabinet including a new Director of Health and Deputy Directors. /2012/Hawaii elected a new Governor in November 2010. Democratic Governor Neil Abercrombie has held various elected offices for more than 35 years, most recently 20 years as a U.S. Congressman. Along with Lt. Governor Brian Schatz, the new Governor assumed office December 2010. Management and priorities are shifting with the replacement of all government department directors with new political appointments.

The Governor's new priorities are:

- Creating Jobs/Economic Recovery
- Investing in People (Education, Early Childhood, Human Services, Housing, Health Care)
- Government Efficiency (Modernizing Technology, Restoring Public Service, Protecting Tax Dollars, Protecting the Environment)
- Balance Budget through government restructuring, exploring new funding streams (alcohol, soda tax are examples); securing Hawaii's fair share of federal dollars.

Governor Abercrombie has appointed a state Homeless Coordinator, Early Childhood Coordinator, Chief Information Officer (to transform the State's antiquated technology system), Chief Financial Officer, and will appoint a Health Transformation Coordinator.

Budget deficits continue to drive programmatic decisions. Legislators increased taxes more than \$600 million this year to balance the state's \$232 million shortfall for fiscal year 2011 that ends June 30 and \$1.3 billion shortfall for fiscal years 2012 and 2013. The Department of Health (DOH) sustained another \$8.6M reduction to general funded programs and an additional \$15 M taken from special funds.//2012//

/2013/ Although indicators pointed to signs of economic stabilization, the Governor cautioned that there still remained great uncertainty in the global and U.S. economies that could adversely impact Hawaii. Thus, the Governor's focus remained on economic recovery and job creation through investments on critical physical infrastructure needs. The Administration also continued to support investments in technology, tourism promotion, and renewable energy as the cornerstone for the State's sustainable future. In the area of health, the Governor confirmed his commitment to Early Childhood programs and combating obesity by funding initiatives in the area and calling for the establishment of an obesity prevention task force. Attention was also given to long-term care concerns and emergency appropriations to support kidney dialysis programs after the sudden closure of 2 Hawaii Medical Center hospital facilities on Oahu. //2013//

WELFARE REFORM

In Hawaii the Department of Human Services (DHS) administers the Temporary Assistance to Needy Families (TANF) program. The state responded to the 1996 federal Welfare Reform Initiative by creating a TANF waiver referred to as PONO (Pursuit of New Opportunities). The waiver expired and is currently operating under federal guidelines.

When the program was implemented in 1996, the welfare population was approximately 20,825 cases. The current population as of March 2010 is 7,356 cases. Of that number, approximately 5,060 clients are identified as eligible to work.

All "able-bodied" TANF cases experience a 20% reduction in their cash benefits in the first year. Those individuals who are currently employed while in the program (about 2,000 individuals) have been able to earn back this 20% reduction plus more by being able to keep more of their earnings through income disregards. As a result those who are employed are in better economic shape than those not employed.

An additional group of over 2,100 recipients are obtaining job experience with volunteer placements. Since July 2007 DHS increased the payment standard in response to the needs of these individuals and to account for the increase in the cost of living.

The First-to-Work (FTW) Program serving parents receiving TANF has been active and services approximately 5,077 cases per month and an unduplicated number of 9,051 per year. //2012/ The current population as of March 2011 is 7,780 cases. Of the current number, approximately 4,990 clients are identified as Work Eligible Individuals. An additional group of over 2,209 recipients are obtaining job experience with volunteer placements. The FTW program services approximately 5,528 cases per month and an unduplicated number of 9,671 per year. //2012//

/2013/ The current population as of March 2012 is 10,281 cases, 2,045 of which are state funded. An additional group average of 1,914 recipients each month is obtaining job experience with volunteer placements. The FTW program, serving TANF recipient parents, has been active and services an average of 6,054 cases per month and an unduplicated number of 12,348 between June 2011 and May 2012. //2013//

HEALTH INSURANCE

Historically, Hawaii has had a large proportion of its population covered by some form of health insurance. In the 1980s, Hawaii's uninsured population was estimated at 5%, and the state was credited as having the lowest uninsured rate in the U.S. This is a legacy from traditional Hawaiian

society; the subsequent plantation era where medical care was provided for workers, and the rise of strong labor unions.

Prepaid Health Care Act

The generally accepted principle of broad or universal access to health care is reflected in the passage of the Hawaii Prepaid Health Care Act of 1974. The Act requires employers to provide a group health plan for employees working at least 20 hours a week for at least four straight weeks and earn at least \$542 a month. The law also mandates a minimum set of benefits that must be provided.

Hawaii is the only State with such a requirement and was successful in obtaining a waiver from the federal Employee Retirement Income and Security Act (ERISA), which prohibits state regulation of self-insured employers. The law does not require employers to cover dependents, so families may be omitted from coverage. Recent large increases in insurance premiums over the past few years have raised concerns about the Act and its impact on businesses in Hawaii. ***//2013/ In 2011, the Administration received legal opinions from the U.S. Department of Health and Human Services and the U.S. Department of Labor that concluded the State of Hawaii could retain the Hawaii Prepaid Health Care Act alongside the federal Patient Protection Affordable Care Act. //2013//***

Private and public health insurance covered an estimated 90 percent of Hawai'i residents in 2007. Private health insurance covered about 56 percent of residents. Of those people covered by private health plans in Hawai'i, 93 percent were covered through employment-based plans. The number of residents in public-sponsored insurance programs remained fairly stable between 1995 and 2007 at about 36 percent of the resident population.

From 1992 to 2007, the proportion of the population with overlapping coverage has increased by 80 percent. (Overlapping coverage refers to an individual's coverage by more than one insurance plan.) In 2007, nine percent of covered individuals, or 1 in 11 individuals, had overlapping coverage.

UNINSURED

Although the Hawai'i resident population is relatively well insured compared to populations in most other states, direct and indirect problems persist. Many low-income Hawai'i residents remain uninsured and a significant number of full-time and part-time workers remain uninsured. Over 50 percent of the total number of uninsured in Hawai'i are working part-time or full-time.

The State uninsured rate was 7.8 % in 2008 compared to 15.4% nationally according to the Census Bureau 2009 Current Population Survey. Hawaii had the second lowest uninsured rate behind Massachusetts. However, this data reflects uninsured rates before the major effects of the state economic decline occurred in 2009.

A disproportionate number of uninsured reside on the islands of Hawaii, Kauai, and Maui rather than on Oahu, where the majority of the state's population lives.

INSURANCE MARKET

Information on Hawaii's health insurance market is from the Hawaii Health Information Corporation. As in the rest of the nation, the two dominant types of managed care organizations are health maintenance organizations and preferred provider organizations. Nearly 35% of Hawaii residents with insurance were enrolled in an HMO in 2007. Of these HMO enrollees, one out of three participated with one of the QUEST plans. Almost 40% of Hawai'i's residents were enrolled in a PPO in 2007.

Traditional fee-for-service coverage declined by 63% between 1992 and 2007, and makes up 11% of covered lives. In 2007, all of the fee-for-service covered lives were covered by public insurance (either Medicare or Medicaid). Both the federal and state governments are in the

process of changing coverage for these populations to managed care options so this percentage is expected to change.

The financing of health care in Hawaii's private sector is dominated by two health plans: the Hawaii Medical Service Association (HMSA, the Blue Cross and Blue Shield plan) which was founded in 1935, and Kaiser which began operating in Hawaii in 1958. In 2007 HMSA insured 60% of the Hawaii market, while Kaiser covered 20%. The other major insurers in the state are Hawaii Management Alliance Association (HMAA) and University Health Alliance (UHA). All 4 insurers are non-profits and exempt from taxes. A new for-profit insurance plan, Summerlin Life & Health Insurance, began offering services in 2005.

Although there was a significant commercial insurance presence at one time, it has dwindled due to the State's isolation, limited consumer market and aggressive competition from the HMSA and Kaiser. To address Hawaii's shrinking health insurance market and rising health costs, legislation was passed in 2002 to regulate health insurance plans to assure insurance rate increases are not excessive, yet sufficient to keep insurance companies viable in the long term. Hawaii was one of the last states in the U.S. to pass such legislation.

Overall, the number of covered lives in government sponsored plans has increased 29% since 1995, while the percent of individuals covered by private plans increased 2%. In total, government programs represented 36% of the covered lives in 2007.

Medicare, the federal government's coverage for the elderly, accounted for 35% of the government program covered lives in 2007; QUEST and Medicaid, state and federally-funded programs, represented 29% and 8% of government funded health plans respectively. TRICARE, the federal government's coverage for military-dependent and military retiree health care, accounted for 28%.

MEDICAID

The Hawaii QUEST Expanded demonstration project is a Medicaid waiver project administered by the Department of Human Services Med-QUEST Division (MQD) that began in August 1994. 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.

In 1996, economic changes led to a tightening of QUEST eligibility. The income requirement was changed from 200 percent of the Federal Poverty Level (FPL) to 100 percent, and enrollment was capped at 125,000 members, down from the high of 160,000. Certain groups are not subject to the cap and can enroll at anytime: 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.

Through a Medicaid QUEST waiver in 2006 DHS also expanded services by covering more low-income adults. Through the new QUEST-ACE (Adult Coverage Expansion) launched by DHS in March 2007 benefits are provided for inpatient and outpatient care, emergency room visits, mental health services, diagnostic tests, immunizations, alcohol and substance abuse treatments, dental care and prescription drug coverage. Men and women over the age of 19 without dependent children are eligible whose annual earnings are at or below 200% of the FPL. The program is designed to help adults who could not previously qualify for QUEST due to the statewide enrollment cap imposed in 1996. The waiver also allowed the state to continue to make direct payments to hospitals to offset the costs of caring for the uninsured.

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 December 2006, DHS reinstated adult dental benefits - including periodic exams and cleanings - to help up to 95,000 men and women eligible for Medicaid. The MQD ended this dental program on August 10, 2009. At this time, the State only pays for emergency dental services, such as tooth extractions for adults.

QUEST allows participants to select medical plans from the three current participating providers: HMSA, Kaiser, and AlohaCare. The three QUEST health plans offer additional services for disease management and some plans will offer health promotion programs for enrollees. Med-QUEST also implemented a new quality assurance program. Plans receive financial incentives for meeting quality performance standards and are assessed penalties if they fail to meet baseline requirements. As of January 2010 HMSA covered 52.1 % of QUEST enrollees, Kaiser 11.8%, and AlohaCare 35.1%, (another 1.0% remain under QUEST FFS). Not all providers are available on each island.

/2012/ As of March 2011 HMSA covered 53.3 % of QUEST enrollees, Kaiser 12.1%, and AlohaCare 33.6%, (another 1.0% remain under QUEST FFS). //2012//

/2013/ From July 2012, the QUEST program will have 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 QUEST members statewide, except for Kaiser Foundation Health Plan, which has chosen to operate only on the islands of Oahu and Maui. As of March 2012 HMSA covered 52.9 % of QUEST enrollees, Kaiser 11.8%, and AlohaCare 34.3%, (another 1.0% remain under QUEST FFS). //2013//

DHS has plans to implement a new economic stimulus program that will increase health care coverage by providing a health insurance premium subsidy to employers who hire unemployed individuals.

/2013/ This program will not be offered. //2013//

QUEST Expanded Access

The Medicaid population of clients 65 years or older and disabled of all ages (commonly called the aged, blind, and disabled (ABD) population) was covered under a separate fee-for-service program. In February 2009, the ABD population transitioned into a managed care system through the new QUEST Expanded Access (QExA) program. MQD designed the QExA program to provide service coordination, outreach, improved access, and enhanced quality healthcare services by health plans through a managed care delivery system to this Medicaid population. QExA health plans coordinate benefits across the continuum of care to include acute and primary care, behavioral health, and long-term care services. In 2008, DHS awarded the 3-year QExA contracts to two new health plans: Evercare and 'Ohana Health Plan associated with national health insurers United Health Group and WellCare of Arizona. Full conversion of Hawaii Medicaid to managed care has enabled the State to contract for Medicaid expenditures with a fixed annual budget.

As of January 2010 the QExA enrollment was 41,671; QUEST enrollment was 205,106 for a total Medicaid enrollment of 249, 875. Due to the state economic downturn, Medicaid programs observed an approximately 13% increase in recipients for two successive years. This unexpected growth of the program with federal restrictions under the American Recovery and Reinvestment Act that prevented states from decreasing eligibility resulted in a budget shortfall and the need to delay two months of health plan capitation payments (one month's for 6 weeks, and a second month's for 2 weeks). DHS earnestly awaits a six-month extension of the increased federal medical assistance percentage.

/2012/ As of March 2011 the QExA enrollment was 43,105 and QUEST enrollment was 218,913. Total Medicaid enrollment was 270,129. To address anticipated budget shortfalls, DHS is proposing changes to Medicaid programs that include new benefit packages for non-disabled, non-pregnant adults less than 65 years old. Benefits for children under the age of 21 will be

maintained. Planning includes a new eligibility system, benefit changes, health information technology, and a Medicaid health home program with community partnerships.//2012//
/2013/ To address a \$75 million budget shortfall, Medicaid will reduce eligibility for adults from 200% to 133% and reduce reimbursement rates. Additional funding became available through an increase in the federal matching rate providing \$15 million, and a supplemental appropriation of \$8 million by the Legislature. Savings also will come from program integrity measures that will include reduction of duplicative enrollment, annual eligibility reviews for adults, fraud reduction, and periodic review of DOH death records. The cost of operating Hawaii's medical assistance programs in 2012 is more than \$1.7 billion dollars in combined state and federal dollars.//2013//

STATE CHILD HEALTH INSURANCE PROGRAM

The State Children's Health Insurance Program (SCHIP), enacted in August, 1997, provided new incentives for states to extend public health insurance coverage to low-income uninsured children. The federal government offered states a higher federal match and greater flexibility to design their programs than they enjoyed under Medicaid. Hawaii uses Tobacco Settlement revenues to fund the State match for SCHIP.

The Department of Human Services (DHS) is the lead agency in Hawaii for the State Child Health Insurance Program (SCHIP). Hawaii's SCHIP program, a Medicaid expansion, began on July 1, 2000, and covers all children under 19 years of age with family incomes up to 300% of the Federal Poverty Level (FPL) for Hawaii. There is no waiting period for SCHIP eligibility. As of January 2010, 23,621 children were enrolled in SCHIP.

/2012/ As of May 2011, 25,173 children were enrolled in SCHIP. //2012//

/2013/ As of March 2012, 27,777 children were enrolled in SCHIP. //2013//

Effective July 1, 2000 children who are legal immigrants arriving after August 1996, refugees and those born in the Marshall Islands and Federated States of Micronesia and Palau were eligible under both SCHIP and QUEST under a state funded immigrant program.

In July 2009, MQD used the provisions of Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to amend the Medicaid State Plan retroactive to April 1, 2009. Section 214 of CHIPRA extends federal medical assistance to alien children under nineteen years of age and alien pregnant women who are Legal Permanent Residents or citizens of a Compact of Free Association nation. Effective July 9, 2009, MQD began to convert the children and pregnant women covered in the State-funded programs to the appropriate Section 1115 QUEST Expanded programs. Therefore, as of January 2010, the immigrant child enrollment was 38 since the majority of children in this program (approximately 3,800) were converted to a Medicaid program that received Federal funds.

/2013/ In 2012, all immigrant children are enrolled in a Medicaid program under CHIPRA. //2013//

STATE DEPARTMENT OF HEALTH: CURRENT PRIORITIES & INITIATIVES

DOH Director Fukino identified the following priorities for the Department of Health in 2006:

- Assuring a viable and sustainable mental health system of care.
- Disaster readiness and response.
- Assuring access to quality health care, including the development of an EMS Trauma System Plan and the expansion of tele-health.
- Assuring a continuum of quality services for the care of seniors and disabled individuals.
- Improving departmental processes, reflective of current business standards.
- Primary Prevention: the promotion of good nutrition, exercise, and smoking cessation.

However, since FY 2009 the Department's budget has been reduced by 17% and has witnessed a 12% reduction in staffing. Therefore, Dr. Fukino has had to reprioritize programs to preserve its regulatory, statutorily mandated services and emergency response capacity. Eligibility criteria for many programs including family health services have been decreased to serve the neediest or

more chronically ill.

/2012/ New DOH Director Loretta Fuddy has identified revised Departmental priorities:

- Improving efficiencies of business processes
- Strengthening Departmental Core Public Health Functions
- Rebuilding Prevention Capacity
- Addressing Health Disparities and Access to Care
- Meeting State & Federal Mandates //2012//

/2013/ In February 2012 the DOH released a new strategic plan for 2011-2014, "Foundations for Health Generations." Developed to coordinate with the Governor's New Day Agenda, the plan focuses on 5 pillars of health: Health Equity, Prevention and Health Promotion, Clean and Sustainable Environments, Emergency Preparedness and Quality/Service Excellence. As a companion to the DOH Strategic Plan, a work plan was also developed to document and monitor progress in achieving fundamental, cost-effective, and sustainable improvement in health status that will improve outcomes and reduce long term cost. The plan will also serve as the foundation for a national accreditation application. //2013//

An attachment is included in this section. IIIA - Overview

B. Agency Capacity

B. Agency Capacity

Public Health in Hawaii, including Title V, continues to focus on the core public health functions of assessment, policy development and assurance as outlined in the 1988 Institute of Medicine Report, The Future of Public Health. While there is still a broad emphasis on ensuring access to quality and affordable health care and the elimination of health disparities, we have seen a shift of resources to address global threats to public health. Greater emphasis has been placed on departmental readiness to address bioterrorism, global disease detection, the pandemic spread of disease and community wide immunization.

A clear example of this was Hawaii's response to the H1N1 pandemic which included state operated school immunization clinics, and coordination with all health care providers for the distribution of vaccines and the tracking of the spread of disease. Hawaii was ranked 8th best in the nation with 24% of its residents vaccinated between October 2009 and February 2010. Hawaii ranked 1st in the nation for regular flu immunization, with 55% of its residents vaccinated.

Also a continued emphasis for the Department of Health (DOH) is the reduction of the burden of chronic disease with a concerted effort to address the obesity epidemic.

Hawaii's Title V programs work to ensure statewide infrastructure building functions such as data collection, needs assessment, surveillance, planning and evaluation, systems and policy development, monitoring, provision of training, and technical assistance to assure quality of care.

The challenge for public health is to assure that the health of the community is improved and protected given that health status is influenced by a myriad of societal influences and the complex and ever changing nature of health care financing and delivery system.

In Hawaii the Title V agency is the Family Health Services Division (FHSD) in the State Department of Health. FHSD is organized into the 3 Branches: Children with Special Health Needs Branch (CSHNB), Maternal and Child Health Branch (MCHB), and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Services Branch. The mission of FHSD is "to improve the health of women, infants, children and adolescents and other vulnerable populations and their families by increasing public awareness and professional education about the importance of a life course perspective; advocating for systemic changes that address health equity and the social determinants of health; and assuring a system of health care

that is family/patient centered, community based, and prevention focused with early detection and treatment, habilitative and rehabilitative services for those with chronic conditions".

Our vision is to assure that systems are in place to address the full continuum of care throughout the life cycle from preconception to birth to adolescence to adulthood for Hawaii's population and address the health and safety needs of vulnerable individuals, children and youth, with particular attention to children with special health needs.

The Division goals are:

1. Pregnancy/conception shall occur by choice and under circumstances of lowest risk.
2. Every woman will utilize appropriate services and engage in healthy behaviors to optimize health outcomes.
3. All infants, children and adolescents, including those with special health care needs, will receive appropriate services to optimize health, growth and development.
4. All families will have a safe and nurturing environment, free of violence and will engage in behaviors to promote optimum health.
5. Access to quality health care shall be assured through the development of a comprehensive, coordinated community-based, patient/family-centered, culturally competent system of care.
6. FHSD shall have the necessary infrastructure to support the implementation of the core public health functions.

COLLABORATION & COORDINATION

The current administration has placed a priority on data and the tracking of health outcomes. Tobacco Settlement funds have been used to fund the Hawaii Outcomes Institute in conjunction with the School of Medicine to increase the research and epidemiological capacity of the state. Similarly, FHSD has strengthened its capacity to perform the ten essential public health functions by encouraging staff to participate in data analysis and management training sponsored by the Hawaii Outcomes Institute. FHSD has enhanced its data capacity through increased partnerships with the DOH Office of Health Status Monitoring; investing federal State Systems Development Initiative, Title V, and Primary Care office resources into the Hawaii Health Survey, the Pregnancy Risk Assessment Survey, and other health surveillance tools; and maximizing use of a Centers for Disease Control-assigned Title V funded MCH epidemiologist. WIC, PRAMS and Birth Defects Monitoring data are included in the DOH's Data Warehouse.

As funding for direct health care services shifts away from public health agencies to the medical community and other providers, the role of the Title V program changes. In the context of this changing health care system, the Hawaii Title V agency works to promote and develop an environment that supports the optimal health of all women of child bearing age, infants, children, adolescents and families. Collaboration and coordination is inherent in the work of the Title V agency; it would be impossible to meet the myriad of Title V objectives without intra and interagency efforts. A few examples of this include the coordination with the DOH's:

- Injury Prevention Program to assess and align our efforts to reduce child abuse, bullying, automobile injuries and sleep related deaths;
- Dental Health Division to address the issue of oral health promotion through WIC, school based and community health clinic activities;
- Healthy Hawaii Initiative to reduce obesity through the joint promotion and physical activity and breastfeeding promotion. Joint collaboration resulted in a two year federal grant for a Baby Friendly Hawaii project;
- Child and Adolescent Mental Health Division and the Mental Health Transformation Grant joint sponsorship of an annual summit to promote infant and child emotional wellness.

//2013/The Dental Health Division was eliminated in 2009 as part of the Reduction-in-Force initiative. Dental services are now limited to direct services provided through the DOH Developmental Disabilities Division.//2013//

Example of inter-agency and community agency collaboration include:

- In conjunction with Kapiolani Medical Center for Women and Children (KMCWC), the

joint creation of cranial-facial clinic;

- Women's Health Month and Children and Youth Month's calendar of events.
- Joint planning of the Hawaii Primary Care Association Annual Meeting;
- In collaboration with DHS and KMCWC, the assurance that all foster children will receive a full physical and emotional evaluation, including an assessment for potential fetal alcohol affects;
- Survey & report on C-section and early induction in collaboration with March of Dimes and Healthy Mothers Healthy Babies;
- Provider training for substance abuse screening and brief interventions in conjunction with Ira Chasnoff, MD, with the Children's Research Triangle.

Although the staffing within the FHSD is relatively small it is able to impact the quality of health care throughout the state due to its ability to contract with community health centers and private health care providers for the provision of direct medical services. All contracts must respond to a core set of objectives and report on the impact of services within their respective communities. Also through the scope of work outlined within the contracts, FHSD requires specific screenings and adherence to standards of care.

STATUTORY AUTHORITY

FHSD falls within the purview of Title 19 Chapter 321 of the Hawaii Revised Statutes SS321-31. Functions of the Department under Part II Preventive Medicine defines the functions of the Department of Health. The powers, duties, and functions of the department of health relating to preventive medicine shall be as follows:

1. To supervise and coordinate activities in the field of preventive medicine, including... crippled children... maternal and child health... nutrition...;
2. To formulate... Programs for the purpose of preventing and reducing disease and disability;
3. To engage in the collection and analysis of statistical information pertinent to any of its activities;
4. To cooperate with and propose methods and programs to other governmental agencies relating to the field of preventive medicine;
5. To serve as the coordinating agency for programs which provide for a range of child abuse and neglect prevention services in relation to assessing needs... and to coordinate the prevention programs with child abuse and neglect treatment services...

There are additional statutes which govern specific program activities within the division. Relative to Primary Care HRS SS 321-1.5 primary health care incentive program allows for needs assessment and the development of strategies to meet the health needs of the medically underserved.

Children with Special Health Needs have several statutes governing its various programs:
HRS SS 321-51-54 Children with Special Health Needs describes its power, duties and activities;
HRS SS 321-291 defines the scope of the Newborn Metabolic Screening Program;
HRS SS 321-351 to 357 Infants and Toddlers defines the eligibility and scope of the Part C Early Intervention Program;
HRS SS 321-361 to 363 defines the scope of the Statewide Newborn Hearing Screening Program;
HRS SS 321-421 to 426 defines the scope of the Birth Defects Program;
HRS SS 321-101 provides authority for Systematic Hearing and Vision Program.

Maternal and Child Health have the following statutes which govern part of its function and activities:

HRS SS 321-1.3 established and defines the scope of the Domestic Violence Special Fund;
HRS SS 321-36 to 38 defines the scope of Child Abuse and Neglect Prevention;
HRS SS 321-321 to 326 establishes the scope of the Maternal and Child Health Program;
HRS SS 321-331 defines the scope and authority of the Prenatal Health Program;

HRS SS 321-344 to 346 provides authority for Child Death Review;
HRS SS 321-471-476 provides authority for Domestic Violence Fatality Review;
HRS SS 350B1 to 7 established and defined the scope of the Hawaii Children's Trust Fund.

While there is no statute specific to WIC services, its activities would fall within the scope of Part VII of the Health statute HRS SS 321-81 Nutrition, which allows for nutritional education, evaluation, and contractual services.

CULTURAL COMPETENCY

The DOH has placed a priority on program responsiveness to the needs of Native Hawaiians and Pacific Island populations. Likewise, FHSD has sponsored trainings and workshops for our staff and our provider network regarding the needs of Hawaii's newer immigrants and have encouraged the spread of best practice for this population. Contracts with the network of community health centers specifically call for the linguistically and culturally appropriate approaches to the division's client base. Presentations at national conferences and the publication of articles regarding promising practices have helped to increase cultural competency within our state.

Hawaii's diversity allows FHSD to include representation from various community and ethnic stakeholder groups on various advisory councils. The Big Island Healthy Start Disparities federal grant has a clear objective to include consumer input in the design of the program, and to include the women from Hawaiian, Pacific Islanders, Hispanic, and Filipino cultures to be active members of its community consortia to improve the system of care for the island of Hawaii.

Collection and dissemination of data analysis specific to the many ethnic groupings within Hawaii have helped to identify needs and behavioral risk of the unique peoples of Hawaii. FHSD has collaborated with the Office of Health Equity to produce a document on the health care needs of Native Hawaiians and Pacific Islanders.

Parent involvement has been a cornerstone for FHSD's Children with Special Health Needs Program. This includes participation in needs assessment, advisory council and informing program design. More recently through the efforts of the Early Childhood Coordinating Systems grant FHSD has placed an emphasis on parent involvement through hosting and promoting "parent café" sessions.

PROGRAM CAPACITY

The three branches of Family Health Services Division (FHSD) target all three major Title V populations: infants and mothers, children and youth, and children with special health care needs.

The following is a brief description of the basic role of the Director's Office, the three branches, the District Health Offices on the neighbor islands, and FHSD planning, evaluation, data analysis capabilities.

DIVISION CHIEF'S OFFICE

The Office of the Division Chief is responsible for overall management, administration, and direction of the Division. Included in this are activities of program planning, development, evaluation, coordination, research, and information technology support. The Division also houses Don Hayes, M.D., M.P.H., the Centers for Disease Control-assigned MCH epidemiologist.

The Title V Director's Office oversees coordination for the Office of Primary Care, Title V, the State Systems Development Initiative, and the Early Childhood Comprehensive Systems (ECCS) grants. The Division lost its state-funded Fetal Alcohol Spectrum Disorder (FASD) coordinator position due to a statewide reduction in force (RIF); however, was able to maintain this function utilizing a CSHN Branch position.

The attached chart shows the staff and functions under the Division Chief. The eight positions

funded (or partially funded) with federal Title V funds are identified on the chart and includes the Branch Chief for CSHN.

CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH (CSHNB)

The Children with Special Health Needs Branch promotes integrated systems of care that assure that children and youth with special health care needs will reach optimal health, growth, and development. CSHNB programs include Newborn Hearing Screening, Newborn Metabolic Screening, Children with Special Health Needs, Early Intervention, Genetics, and Birth Defects Programs. CSHNB works to improve access for CSHCN to a coordinated system of family-centered health care services and improve their outcomes, through systems development, assessment, assurance, education, collaborative partnerships, and supporting families to meet their health and developmental needs. Direct and enabling services are provided as mandated by law, as a safety net for CSHCN/families who have no other services, and to improve access of CSHCN to needed health care services. CSHNB now has 151 FTE time positions, of which 12 are Title V funded. The total number decreased due to loss of 53 positions that were abolished or eliminated as a result of the statewide Reduction in Force (RIF) process in late 2009, which also forced closure of the Preschool Developmental Screening Program and Wahiawa and Kona Early Childhood Services Programs.

MATERNAL AND CHILD HEALTH BRANCH (MCHB)

The Maternal and Child Health Branch is now comprised of approximately 39.5 FTEs, of which 15.5 are Title V funded, 7 are state funded and 17 are funded by other federal sources. The total number decreased due to the loss of 13 positions that were abolished or eliminated as a result of the RIF process in late 2009. Additionally 1 Title V position and 1 TANF position were eliminated due to budgetary restrictions. The Branch strives to promote and protect the health and well-being of mothers, infants and children and their families in the context of the communities in which they live. The Branch is divided into three major programmatic areas: Women's Health Section (which administers the federal Title X family planning program); Family and Community Support Section and an Administrative Section comprised of fiscal and data units. Due to the RIFs, the branch lost its Children & Youth Wellness Section and is currently reviewing its administrative organization for possible revision. The MCH Branch oversees a network of non-profit and private providers with contracts for direct, enabling, and population-based services focused on women and their families. Program staff work collaboratively with community partners to provide leadership and support for core public health functions in the State. Strategies include needs assessment, system development, mobilization of community partners and coalitions, surveillance of health status and utilization, and support of best and promising practices to enhance service delivery and build community capacity. The Branch continues to support a broad mandate with limited infrastructure.

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, & CHILDREN (WIC)

The Special Supplemental Nutrition Program for Women, Infants & Children (WIC) is a federally funded short-term intervention program designed to establish good nutrition and health behaviors through nutrition education, breastfeeding promotion, a monthly food prescription allotment and access to maternal, prenatal and pediatric health-care services. WIC serves low-income pregnant and post-partum women and children up to age 5 nutritionally at-risk through purchase-of-service (POS) and state-run agencies. WIC contracts with seven community health centers, one Native Hawaiian Health Care Center and one hospital to provide services, resulting in greater integrated health service delivery than the eight state-run agencies. During FFY 2009, Hawaii WIC served a monthly average of 36,320 individuals, an increase of 6.7% from 34,050 individuals in 2008. The mix is approximately 25% women, 25% infants and 50% children. The new WIC food packages effective October 2009 (with reduced fat milk, fruits/vegetables, whole grains, baby foods and soy alternatives) aligns with messages to increase intake of fruits/vegetables and whole grains/fiber, decrease intake of fat and juices, and breastfeed babies. The gradual change to a more paraprofessional delivery model continues as does the emphasis on participant-centered services. Over 12% of the trained state WIC staff (14 of the 113.5 FTEs) was replaced in some

cases with higher salaried more senior staff during the 2009 RIF process; further vacancies exist for qualified nutritionists due to two hiring freezes. Some POS agencies have accepted additional caseload and funds, but furloughs for state employees have impacted potential caseload and spending. ARRA funding will be used to plan the replacement of the 11-year old information technology system.

/2012/ During FFY 2010, Hawaii WIC served a monthly average of 37,029 individuals, a modest increase of 2% (36,320 in previous year). The branch contracted for phone calls for appointment reminders and missed appointments to compensate for furlough days. Furloughs for federally funded employees ended in May 2011. The reminder phone calls may be continued. The branch is currently reviewing proposals for the POS WIC services starting October 2010; for the first time, breastfeeding peer counselor (BFPC) services was included as an option to core WIC services. Plans are to establish two exempt positions to assist with BFPC efforts. The branch contracted for a feasibility study to replace the IT system; the new system is required to be EBT-ready by 2020. Plans are to improve the WIC Allowed Food List by increasing the choices while remaining cost-neutral effective October 2010 and to investigate allowing farmers to redeem fruit and vegetable vouchers. //2012//

/2013/ During FFY 2011, Hawaii WIC's monthly average decreased slightly from 37,029 individuals to 36,753 (<1%) which was less than the national decrease of >2% possibly attributed to lower birthrates. Contract for automated phone call reminders and missed appointment calls continued. Extensive technical assistance for two new providers for Molokai and Lanai started October 2011 and April 2012, respectively; all other providers remained. Three exempt breastfeeding peer counselor positions are being filled and a project manager being recruited for a replacement IT system. Cost-neutral changes to the WIC allowed foods are on hold pending USDA's final rule. Efforts to change client behavior by offering participant-centered services continue. //2013//

/2013/ FHSD currently has a reorganization proposal under review as part of a larger Departmental reorganization initiative. The planned reorganization for the FHSD includes deleting positions, functions and structures that were lost in the 2009 RIF. It also serves to better position the Division for rebuilding in the future when conditions improve. The DOH Office of Rural Health will be merged with the FHSD Office of Primary Care to create a combined Office of Primary Care and Rural Health under FHSD. The epidemiological function will be enhanced with the creation of a new Surveillance, Evaluation and Epidemiology unit also at the Division level. Formal transfer of several positions will occur to reflect current functioning. The Children with Special Health Needs Branch is being restructured to improve efficiency and create a more equitable distribution of workload across the branch. A new Genomics Section will be established to reflect current trends in this area of public health and will consolidate programs with similar target groups (i.e. newborn screening). The Maternal and Child Health Branch is undergoing substantial restructuring after the loss of a major child health section to improve utilization of remaining resources. //2013//

DISTRICT HEALTH OFFICES

Administration of all Department of Health programs on the neighbor islands are provided by the three District Health Offices (DHO) located on the islands of Kaua'i, Maui and Hawaii and follow political county jurisdictions. Kaua'i DHO is also responsible for the island of Ni'ihau. Maui DHO is responsible for the islands of Lana'i and Moloka'i. Each DHO has a Registered Nurse with public health experience, who functions as the FHSD Coordinator responsible for the administration of FHSD programs: CSHN (including Early Intervention Services), Maternal and Child health. Maui and Kaua'i coordinators also oversee WIC, while Hawaii island WIC oversight is managed within the WIC program. Each office may also administer grants specifically designed to target the needs of their rural island communities.

Coordinators have also been active in DHO initiatives such as School Flu Clinics and disaster preparedness activities. Coordinators and other FHSD staff have been involved with the

response to the H1N1 outbreak and investigation.

Neighbor Island FHSD Coordinators are uniquely positioned at the community level to ensure coordinated service delivery to consumers. Based on community needs, the Coordinators are responsible for providing all levels of service delivery from Direct to Infrastructure Building Services. Neighbor Island Coordinators and EIS staff are also closely involved with building the system of service delivery for State Department of Education Special Education programs under IDEA. This is not the case for the Division offices on O'ahu. On O'ahu, programs for school age children under IDEA are coordinated largely between the Department of Health's Child and Adolescent Mental Health Division and the State Department of Education.

Each Neighbor Island FHSD office is organized somewhat differently. The FHSD Coordinators often oversee many other District Health Office functions and responsibilities for other health areas.

HAWAII COUNTY

The FHSD Neighbor Island Coordinator responsibilities on the Island of Hawaii are handled by a Nurse Manager for Special Services, Maylyn Tallett. She provides supervision and support for Title V programs which include the Children with Special Health Needs Program (1 social worker in East Hawaii; 1 social worker and 1 half-time office assistant in West Hawaii); Early Intervention Program (2 social workers in East Hawaii); Maternal and Child Support Services Program (1 RN and 1 office assistant in East Hawaii); Special Services Administration (1 office assistant), and Administrative supervision for the Office of Health Care Assurance Program (1 RN).

Due to RIFs in late 2009 the Kona Early Intervention Services Program was closed (11 positions total). Two positions for the Children with Special Health Needs Program were eliminated (1 early intervention specialist in East Hawaii and 1 half-time office assistant position). In the Maternal and Child Support Services Program 2 positions were lost (1 RN in West Hawaii and 1 social worker in East Hawaii). Additional supervision is provided to the Office of Health Care Assurance Program staff located within the HDHO.

The Maternal and Child Support Services Program provides on-island oversight of purchase of services (POS) contractors, participates in local area consortia activities, and engages in administrative functions for the Healthy Start Initiative: Eliminating Disparities in Perinatal Health - Big Island Perinatal Health Disparities Project (Project).

In addition to program supervision, the FHSD NI Coordinator is an active participant with community organizations such as: East Hawaii Coalition for Child Abuse and Neglect Prevention; Family Violence Interagency Committee; Upstream Perinatal Solutions; Hawaii Island Dental Health Task Force; Tri-County Dental Health Task Force; Child Safety Collaborative; Child Death Review Committee; State FASD Committee and Project related activities both administratively and directly with the Local Area Consortia's in Kau, North Hawaii, East Hawaii and West Hawaii.

The Hawaii District Health Office serves an important role in the health and safety of our local residents therefore, must be prepared to serve the community at all times. All FHSD staff participate in disaster preparedness trainings by taking part in un-announced call-downs, attend in-services for designated Bioterrorism Response Teams (BRT). Collaboration with the County level programs and local area agencies are vital to a seamless system of communication for timely notifications of tsunamis, hurricanes, extreme vog conditions, road closures, announcements of out of control fires (exacerbated by severe drought conditions) and earthquake disaster assistance. Also, FHSD programs participate in the annual school flu clinics and other community disaster related exercises. All employees are given the opportunity to undertake leadership roles and supportive functions to increase their knowledge and skills with the State Department's emergency response system.

The major challenge for HDHO is assuring access to services for the county's rural communities

given the changing demographics of these areas as new residents move into remote areas of the island. The state reduction in force and the elimination of many family support programs has forced existing programs to reorganize, shift priorities, and encourage increased collaboration among Federal, State, County, and local area agencies to increase efficient delivery of existing services.

/2012/ A new eruption on the east rift of Hawaii's Kilauea Volcano has boosted visitation to Hawaii Volcanoes National Park. Strong trade winds have eased the vog conditions since the new eruption but vog is still present especially along the southern coast of the Big Island.//2012//

/2013/ The Hawaii District Health Office is currently reorganizing to align programs statewide and to restructure operations after the 2009 reduction of work force. The Women, Infant & Children (WIC) program will be moved under the direct supervision of the Nurse Manager to include an additional 18 positions. //2013//

MAUI COUNTY (Includes islands Maui, Molokai & Lanai)

The FHSD programs in Maui Tri-Isle County (Maui, Lanai, Molokai) are supervised by a registered nurse (RN), Jeny Bissell, who is responsible for the administrative supervision of all FHSD programs and employees, which includes WIC (2 nutritionist, 4 nutrition assistants, 2 nutrition aides, 3 office assistants), Early Intervention (1 social worker), CSHN (1 social worker), MCH (1 registered nurse), and a office assistant. The MCH RN position is approved to start August 2, 2010 after a vacancy of 4 months.

Substantial time is devoted toward building a coordinated system of services, in collaboration with the Department of Education, Part C, Part B Agencies, Medical and Dental Providers for children eligible for IDEA services and 504 Special Accommodations; with the Department of Human Services/Maui Child Welfare Services, Maui County Government, Judiciary and their Purchase of Services Contractors for abused and neglected children; with the Maui County 501C-3 Non-Profit Organizations providing family support and family strengthening services; with the Maui Continuum of Care for the Homeless Communities.

Additional duties include special projects related to Title V, FHSD, and/or the Maui District Health Office such as the Injury and Violence Prevention Projects; Domestic Violence (DV) Fatality Review and Child Death Review Teams; and Maui Tri-Isle County Medicaid/Quest Expanded Access Program Stakeholders Coalition to assure access to care for the Aged, Blind and Disabled Population.

The FHSD Supervisor/Coordinator and MCH Coordinator continue to help coordinate various projects and initiatives (i.e. FASD Training, capacity building and staff/service providers training, health promotion, cultural competency training, public awareness/education, and Fall Prevention activities).

The FHSD Supervisor/Coordinator is part of a 5 member team selected to participate in the PREVENT (Prevent Violence through Education, Network and Technical Assistant) Institute at the University of North Carolina School of Public Health. Maui was one of 16 National Teams selected to receive training and mobilize a community based effort to prevent child maltreatment. The 6 months project established the Ho'oikaika (To Strengthen) Partnerships with the goal to create a seamless safety net of CAN prevention services for children and their caregivers.

Maui Tri-Isle County has lost programs and services as a result of budget cuts and poor economy. Because of this, public-private collaborative partnerships are more evident. Additionally, informal partnerships with consumers are also evident in many of the activities and efforts to maximize our existing and very limited resources, especially in efforts to effectively serve the most vulnerable populations. Maui FHSD Staff have been challenged by increasing client caseload with limited resources.

/2012/The new Maui MCH Coordinator started in August 2010. This position serves as the liaison

between MCHB central office on Oahu and the County. The MCH Nurse coordinates the Maui Tri-Isle County Child Death Review Team and serves on the Maui Suicide Prevention Task Force, Central Maui DV Task Force, Maui Homeless Alliance, Maui Oral Health Task Force, Maui Breastfeeding Alliance, Worksite Wellness Committee, Grandparents Raising Grandchildren Coalition, the Women and Children/Pediatrics/Perinatal Safety Committees of the Maui Memorial Medical Center. She conducts education presentations/outreach on the Title V MCH priorities (i.e. bullying prevention, childhood obesity) and provides assistance for worksite wellness activities. The FHSD Coordinator chairs the State Citizen Review Panel for the state Child Welfare Services to assure progress on state plan improvements. In October 2010 one of 2 WIC nutritionist positions was filled after several years of vacancy.//2012//

/2013/ A new CSHN Social Worker was hired on April 1, 2012. There are several positions that remain vacant including the WIC Public Health Nutritionist III and IV and an Office Assistant III. The MCH RN position will be vacated in August and will not be authorized for recruitment due to limited Title V funding. The FHSD Coordinator will be resigning from several community commitments to assume the MCH RN responsibilities including Chair of the State Citizen Review Panel for CPS, Chair of the Maui CPS Advisory Council, and Secretary of the Maui Children's Justice Committee.//2013//

KAUAI COUNTY

The Kauai FHSD programs are supervised by a registered nurse Cashmire Lopez. She provides the administrative supervision and support to all FHSD programs/personnel which include FHSD Secretary, Children With Special Health Needs Program (1 social worker), WIC (1 registered dietitian, 3 nutrition aides, 1 clerk-typist, 1 clerk), Maternal & Child Health (1 nurse coordinator), and Early Intervention Section (2 social workers). Due to budget cuts and reduction in workforce, the FHSD has lost 1 social worker at Early Intervention. The Maternal & Child Health nurse position is currently vacant and therefore, the FHSD program manager is responsible to cover these areas.

The FHSD Coordinator is also responsible for several Title V service contracts and grant funded initiatives on the island which includes family planning, perinatal support and HIV/STD prevention services. Other related MCH duties include leadership roles on the Primary Health Care Consortium, (to address health care access and elimination of health disparities), Kauai Dental Health Task Force, Medical Home Initiative, Kauai Drug Task Force, Kauai Community Children's Council (partnership for IDEA children's services), Mokihana Project (partnership with DOE and Child & Adolescent Mental Health for coordinated school-based mental health services), Good Beginnings Alliance Kauai (integrating child care and early preschool into the broader community system of services and supports for young children and their families), Tobacco Free Kauai Coalition (to decrease smoking during pregnancy), Get Fit Kauai Coalition (promoting physical activities and good nutrition), and Kauai Domestic Violence Task Force (reduce violence and sexual abuse in adults & children).

The FHSD Coordinator is also involved in managing the Kauai Rural Health Association and the Hawaii State Rural Health Association (to improve the network of health services to assure responsiveness to community needs). The Coordinator also participates in the Tri-county Dental Task Force (to raise the level of oral wellness in the community and improve oral health of children) and Kauai Children's Justice Center Interagency Council (development of interagency agreements to address needs of Children of Abuse and Neglect and protect health and safety of women, children and youth).

The Coordinator serves on the Hawaii State Rural Health Association Board of Directors which assures the network of health services is responsive to the needs of people living in rural areas of Hawaii. Board members advise on health policy and allocation of resources. The Coordinator is also involved with a new initiative to establish a Statewide Sexual Assault Response network to ensure services to sexual assault victims are responsive, effective, and forensically sound.

Additional collaborative initiatives on Kauai include SNAPed (Nutrition and Physical education) a food stamp nutrition education project and a recently awarded American Recovery and Reinvestment Act (ARRA) grant pertaining to obesity prevention, which will include hiring a full-time Breastfeeding Coordinator for Kauai WIC to promote and encourage breastfeeding and breastfeeding friendly hospitals on the island of Kauai.

/2013/The FHSD Coordinator now supervises the HIV/STD Program (1 epidemiologist) and WIC staffing has changed to a registered dietitian, 2 nutrition aids, a nutrition assistant, a clerk-typist, and a clerk. In April 2012 the FHSD Coordinator position became vacant and was filled in July by Ms. Sheryl Keliipio who was serving in the MCH nurse position. Like Maui, the now vacated MCH RN position will not be authorized for recruitment due to limited Title V funding.//2013//

CONTRACTED SERVICES

The Hawaii health delivery system depends on public-private partnerships for the delivery of all services, including MCH services. The vast majority of community prevention, primary care and specialty services are provided by private health care providers and community-based non-profit organizations. FHSD contracts with a wide range of these providers (both public and private), using a competitive bid process for most of its community-based services. Nearly 150 purchase of service contracts, memorandum of agreements and fee for service contracts were executed in state fiscal year 2009 totaling nearly \$40.5 million to deliver direct, enabling, population based and infrastructure building services to the MCH population.

/2012/There was a substantial reduction in State funds between state FY 2009 & FY 2010 to FHSD. Although the contract database is not completely updated with the FY 2010 appropriations, there are roughly 115 POS contracts totaling approximately \$29.6 million in state FY 2010.//2012//

/2013/The Family Health Services Division had approximately 139 POS contracts totaling \$36 million in state FY 2011.//2013//

An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

The Department of Health (DOH) is one of the major administrative agencies of state government with the Director of Health reporting directly to the Governor (see attached chart). DOH works with the Governor-appointed Board of Health to set state public health policies. The DOH is divided into 3 major administrations (see attached chart), one of which is the Health Resources Administration (HRA). There are 6 major divisions within HRA including the Family Health Services Division (FHSD), which is responsible for the administration of all Title V funding. The three branches within FHSD are the Maternal and Child Health, WIC, and Children with Special Health Needs Branches.

The Governor appoints all state department directors and deputy directors. Governor Linda Lingle was elected in 2001 and is currently ending her second term and final term as Governor as mandated by state term limits. Dr. Chiyome Fukino, M.D. is the current Director of Health and has been in that position since 2001. Michelle R. Hill is Behavioral Health Deputy; Ms. Susan Jackson is the Administrative Deputy, and Laurence K. Lau, Esq. is the Environmental Health Deputy. The HRA deputy position has been vacant since February 2009. Dr. Fukino and Ms. Jackson have shared supervision responsibility for HRA. FHSD has been under the supervision of Ms. Jackson since June 2009.

/2012/With the election of a new Governor, Ms. Loretta Fuddy, former FHSD Chief, was appointed the new Director of the Department of Health. Mr. Keith Yamamoto, former Alcohol & Drug Abuse Division (ADAD) Chief is the Deputy Director and Mr. Gary Gill is the Environmental Health Deputy, former Environmental Health Deputy under the previous Democratic Administration. The Deputy positions for the Behavioral Health Administration (BHA) and Health Resources Administration (HRA) are currently under recruitment. Mr. Yamamoto has supervision responsibility for BHA and Ms. Fuddy oversees HRA.

Attached is the official DOH organization chart. The chart does not yet reflect some of the organizational changes made as a result of the 2009 statewide Reduction in Workforce action.//2012//

***/2013/ The new DOH Deputy for BHA is Lynn Fallin and the Deputy for HRA is Dr. David Sakamoto. The attached DOH organization chart does not yet reflect the organizational changes made as a result of the 2009 statewide Reduction in Workforce action. DOH is currently reviewing reorganizational plans submitted by its various administrative Divisions/Units, including one for FHSD, that reflects the current changes. Copies of the detailed FHSD org charts are available upon request from FHSD at the time of the federal Block Grant review. //2013//
An attachment is included in this section. IIIC - Organizational Structure***

D. Other MCH Capacity

There are approximately 380 full-time equivalent employees in FHSD. This includes temporary and permanent positions. Of the total, roughly 27 FTEs are funded using federal Title V monies (5.5 at Division level, 8.5 at CSHN Branch and 13 at MCH Branch). Most of the Title V funded positions have been created to build the Division/Branch level infrastructure capacity.

/2012/ There are approximately 334 full-time equivalent employees in FHSD. This includes temporary and permanent positions. There were 29 vacant State funded permanent position counts that were eliminated in fiscal year 2012 due to lack of funds. Four positions were converted from temporary to permanent for the Newborn Metabolic Screening Program in fiscal year 2012. Of the total positions, roughly 28.25 FTEs are funded using federal Title V monies (5.5 at Division level, 9.75 at CSHN Branch and 13 at MCH Branch). Most of the Title V funded positions have been created to build the Division/Branch level infrastructure capacity.//2012//

Approximately 67 FTEs of the Division employees are based in the three district health offices on the neighbor islands: 37 FTE on Hawaii island, 12 on Kauai and 18 on Maui.

/2013/ Staffing has remained largely the same as the previous year. Due to limited Title V funding, the vacant MCH nurse positions on Maui and Kauai, a Children with Special Health Needs nurse, and a CSHNB clerical support position will not be filled. //2013//

The Division has 1 epidemiologist position located at the MCH Branch. Currently, a CDC-assigned epidemiologist works at the Division level. Plans are underway to establish another epidemiologist position at the Division level. The Division also has 7 research statisticians at Division and at the MCH and CSHN branches; 5 planner/program specialists in the Division and MCHB; and 13 data processing staff at Division and at WIC and CSHNB.

/2013/ WIC is currently seeking to establish a new Research Statistician position using WIC federal funds. //2013//

The State budget has been a deficit situation for several years. The Department of Health experienced a Reduction in Force in October 2009. This resulted in the abolishment of 319 positions department wide; and 58 positions within FHSD. Over the last three years there has been a concerted effort by Governor Lingle to downsize state government. Her goal was to eliminate a 1,000 positions statewide; to date 817 positions have been abolished; this in addition to the deletion of many vacant positions. To avoid further layoffs, government workers have been furloughed two days a month in the administrative, judiciary and educational segments from October 2009 through June 30, 2011. The University of Hawaii staff accepted a 6.7% cut in pay; to be reinstated after two years. The greatest controversy has been the furloughing of public school teachers and support staff, resulting in Hawaii having the lowest number of school days per year in the nation.

Due to anticipated State budget deficits the program has been under a periodic hiring freeze despite pending vacant positions. All federally funded positions have been approved for hire by the Governor. Most State general funded positions which are approved for filling are those which

are under court mandates, i.e. Early Intervention Services and Healthy Start. The Division is aggressive in its attempts to seek private foundation and federal grants to continue to advance the goals and objectives of Title V.

/2012/ Due to anticipated State budget deficits the program has been under a hiring freeze for all State funded vacant positions. All federally funded positions have been approved for hire by the Governor. The Division continues to be aggressive in its attempts to seek private foundation and federal grants to continue to advance the goals and objectives of Title V. //2012//

/2013/ There were no significant budget changes between State fiscal year 2012 to State fiscal year 2013. The only addition to the Family Health Services Division's budget in State fiscal year 2013 was for the childhood obesity prevention program under the category entitled, "Program Income." A total of \$250,000 from the Hawaii Tobacco Settlement Special fund is being used to address childhood obesity. The only other noteworthy change between State fiscal year 2012 and State fiscal year 2013 is a 5% reduction in State funds for labor savings which amounts to \$199,096. //2013//

Fiscal Year 2010-2011 administrative budget proposed additional restrictions to health and human services programs. The Hawaii State Legislature has appropriated more than \$23M of Emergency and Budget Reserve Fund to restore partial services which impact vulnerable populations including the elderly and children. Healthy Start Home Visitation program was appropriated \$1.5M of these reserve (Rainy Day) funds and \$1.6M of TANF funding. "Rainy Day" funds were also appropriated to for Waianae Coast Comprehensive Health Care Emergency Room, Kokua Kalihi Valley Comprehensive Family Services, and Hawaii Medical Services Association to restore the Keiki Care program. In addition the Legislature set aside \$67 M of the Hurricane Relief Funds to end furloughs for the 2011 School Year. The Governor has until the middle of June to veto any part of the Legislative Budget.

/2012/ The 2011 Legislature appropriated \$21 million in State funds to address shortfalls in purchase of service contracts for early intervention services. By the same token, the Family Health Services Division received budgetary restrictions of \$327,000 for contracted health and human services programs in fiscal year 2012. Although furloughs were eliminated in State fiscal year 2012, there was a 5% reduction in compensation for all positions in fiscal year and a corresponding "supplemental time off" of 6 hours per month for affected employees.//2012//

Brief biographical information on the FHSD senior level management staff is presented.

LORETTA FUDDY, FHSD Division Chief

Ms. Loretta Fuddy holds degrees in sociology, social work, and public health from the University of Hawaii. She is currently the Chief of Family Health Services Division, serving in this position for eight years. Two years prior, she served as DOH Deputy for Administration. Her area of expertise for thirty-five years has been in the promotion of health and social services for women and children through the State of Hawaii. Ms. Fuddy has made numerous national and international professional presentations regarding the subject of maternal and child health prevention programs. She serves as clinical faculty for the University of Hawaii Department of Public Health and School of Social Work. She serves as a health consultant to Hawaii's efforts to reform and improve its child protective services. She is also a board member for the March of Dimes, Chapter of the Pacific, the Hawaii Children's Trust Fund, and Hawaii Early Learning Council. She has been a member of the Association for Maternal and Child Health Programs Executive Committee since 2006, currently serving as Secretary and is a member of AMCHP's Work Force Development and Emerging Issues Committees.

/2012/ With the election of a new Governor, Ms. Loretta Fuddy, former FHSD Chief, was appointed the new Director of the Department of Health. Currently, the Division Chief position is under recruitment for a temporary replacement. The three FHSD Branch Chiefs are rotating monthly to provide coverage for the Chief position.//2012//

/2013/ With the appointment of Ms. Loretta Fuddy, former FHSD Chief, as the Director of Health for the full term of the current Governor, the Division Chief position has been filled for the duration by Danette Wong Tomiyasu to serve a similar term.

Ms. Danette Wong Tomiyasu joins the Family Health Services Division bringing with her over 20 years of public health program administration and policy experience in family planning, school health and chronic disease prevention and health promotion. Ms. Tomiyasu served at the Seattle-King County Department of Public Health as lead Health Educator for the Family Planning Program and as School Health Program Manager for 10 years. She also served as the Government and Community Relations/Special Projects Manager for a Hawaii, non-profit, managed care health plan founded by Community Health Centers. Since 2001, she served as the Hawaii Department of Health's Chronic Disease Management and Control Branch Chief. Ms. Tomiyasu has served on a number of national boards including the National Association of Chronic Disease Directors and the Directors of Health Promotion and Education. Ms. Tomiyasu has a Masters of Business Administration in Health Care Management. //2013//

DR. PATRICIA HEU, Children with Special Health Needs Branch Chief

Dr. Patricia Heu, MD, MPH, is a pediatrician and has served as the Children with Special Health Needs Branch Chief since 1997. She received her medical degree from the University of California San Francisco and her degree in public health from the University of Hawai'i. She completed her pediatric residency with the University of Hawaii/School of Medicine/Department of Pediatrics. Her prior DOH experience includes Medical Consultant to the Maternal and Child Health and School Health Services Branches, and Clinic Pediatrician and Clinical Director for the Waimanalo Children and Youth Project (serving a rural community on the island of Oahu). She serves on numerous advisory bodies and committees concerning CSHCN.

BARBARA YAMASHITA, Maternal and Child Health Branch Chief

Barbara Yamashita, MSW, has over 30 years of experience in health care, social services and public health providing direct services as well as in leadership positions. Ms. Yamashita served as hospital administrator, worked in the area of child abuse and neglect and youth services, and has both private non-profit as well as government experience. At the Hawaii Department of Health (DOH), Ms. Yamashita was Chief of the Community Health Division which included the chronic disease programs and public health nursing; she also served as the Chief of the Preventive Health Services Branch and was a section supervisor of perinatal services. Ms. Yamashita attended graduate school on a Maternal and Child Health stipend.

//2013/ Barbara Yamashita moved to the Deputy Director position at the state Department of Human Services in February 2012. In June 2012, Ms. Terri Byers was hired as the new MCH Branch Chief. She had served nearly a year in the position for a few months in 2009.

Ms. Byers has over 15 years of dedicated experience in public health and has previously served in the Department of Health (DOH) as Chief in the Office of Health Care Assurance; Planner in the Office of Planning, Policy and Program Development; Project Manager in the Office of the Director; Early Childhood Coordinator with the Healthy Hawaii Initiative; and has most recently served as the Office of Primary Care and Rural Health Communities Coordinator. Prior to working at DOH, Ms. Byers was vice president of the Healthcare Association of Hawaii, the non-profit organization representing Hawaii's healthcare providers including all the acute care hospitals, home care agencies and hospices, as well as community based providers. She also worked for 12 years on Capitol Hill, working for two members of the Hawaii Congressional delegation.//2013//

LINDA CHOCK, WIC Services Branch Chief

Linda Chock, MPH, RD has served as WIC Director and Chief, WIC Services Branch since 2002. She previously served as the WIC Clinic Operations Section Chief since 1997. She holds a BS in Food Science & Human Nutrition and a MPH in Public Health Nutrition, both from the University of Hawaii. Her 34 years of experience includes clinical and administrative dietetic work at both private and public hospitals, public health nutrition education, and nutrition program planning and management at federal, state and regional levels of government. She worked in Texas, California and Missouri before returning to practice in Hawaii.

DR. LOUISE IWAISHI, Medical Director

Dr. Iwaishi is currently Medical Director for the Family Health Services Division. She had been in private pediatric practice in a multispecialty group for 10 years before joining the faculty of the University of Hawaii John A. Burns School of Medicine (JABSOM) in 1991. As assistant professor in the Department of Pediatrics, her focus has been residency training in primary care and developmental pediatrics. She is Director of the Hawaii Maternal Child Health Leadership Education in Neurodevelopmental Disabilities program (graduate level interdisciplinary training) and the Community Pediatrics Institute (pediatric residency training in child health and Medical Home advocacy). She studied Zoology at Pomona College in California, received her M.D. from the University of Hawaii, JABSOM and completed her pediatric residency training at Kapiolani Medical Center for Women and Children's pediatric integrated residency program. Dr. Iwaishi is a past president and continues to serve on the Board of the American Academy of Pediatrics-Hawaii Chapter where she advocates for child health issues related to Title V and AAP initiatives (e.g. Family Voices, Early Intervention Screening/Referral, Medical Home community resources and EPSDT services).

PARENT INVOLVEMENT IN CHILDREN WITH SPECIAL NEEDS PROGRAMS

The Children with Special Needs Branch programs involve families in various ways, including councils, task forces, and advisory committees; development and review of educational materials; participation in presentations and panels; participation in conferences and training sessions; interview panels for staff positions; advocacy for legislation; and input on proposed changes for policies and procedures. Parents are compensated or assisted in various ways including stipends; airline coupons and ground transportation for Neighbor Island families; and child care during activities. Family participants are of diverse ethnic and cultural backgrounds.

E. State Agency Coordination

DEPARTMENT OF HEALTH

Within the Department of Health, Title V works with the neighbor island District Health Offices and various Divisions/programs including the Healthy Hawaii Initiative (the department's chronic disease management & prevention program), Developmental Disabilities, Child and Adolescent Mental Health, Alcohol and Drug Abuse, Disease Outbreak and Control, Emergency Medical Services/Injury Prevention and Control Program, Public Health Nursing, Dental Health, Office of Health Status Monitoring (vital statistics), the State Health Planning Agency as well as the Environmental Health Administration.

The State Primary Care Office (PCO) is located within the Title V agency and works in partnership with public, private and voluntary organizations that are committed to the medically underserved in the State including, the Hawaii Primary Care Association, the Hawaii Area Health Education Center, the Native Hawaiian Health organizations, the Native Hawaiian Scholarship Program, the Hawaii Dental Association, neighbor island District Health Offices, and other state agencies.

DEPARTMENT OF EDUCATION

Hawaii has a single unified public school system serving kindergarten to grade 12. Over 182,000 students are enrolled in public schools, roughly 84% of all students enrolled in educational institutions.

Efforts to promote healthy habits among students and school staff fall under the direction of a new Board of Education policy known as the Wellness Guidelines which requires each school to develop policies and practices to improve nutrition and promote physical activity. The Department's Healthy Hawaii Initiative is the liaison with DOE on the School Wellness Initiative.

CSHNB/Early Intervention Section (EIS) works collaboratively with the DOE in several areas:

- EIS and DOE develop transition materials and regularly provide joint training to early

interventionists, DOE staff, families, and other community members.

- Depending on the availability of funds, EIS supports the continuation of early intervention services for DOE-eligible children with Autism Spectrum Disorder who turn 3 during the summer months until their DOE school year starts.
- The State Interagency Quality Assurance Committee provides oversight and leadership for the quality assurance system that monitors the quality and effectiveness of services for children and youth with special needs. Members include the DOE, DOH (Family Health Services Division, EIS, Child and Adolescent Mental Health Division, Developmental Disabilities Division, and Alcohol and Substance Abuse Division), DHS, Family Court, and Hawai'i Families as Allies.

WIC serves with representatives from the DOE's Office of Hawaii Child Nutrition Programs (OHCNP) on a variety of committees. WIC works with the DOE School Food Services to coordinate the amount of formula provided by DOE versus WIC.

DEPARTMENT OF HUMAN SERVICES

DHS houses programs critical to the health and welfare of the state MCH population including Medicaid EPSDT, Temporary Assistance to Needy Families (TANF), Food Stamps, Child Welfare Services, Disability Determination, Vocational Rehabilitation, Child Care Services, and Youth Services Programs.

DHS Med-QUEST Division (MQD) provides reimbursement to DOH for early intervention services for QUEST-eligible infants and toddlers who are developmentally delayed or biologically at risk.

MQD has updated the EPSDT examination form, which includes immunizations, screening, referrals, and care coordination needs. The standardized form provides providers with clear guidelines about the required examination components, and provides information on screenings and immunizations by various ages. The Family Health Services Division provided input to DHS on this form. MQD is assuring diverse community participation and expert advising regarding EPSDT through methods such as topical meetings with specific stakeholders.

The DHS also experienced a reduction in workforce and the EPSDT Coordinator position was vacated. The MCHB will follow up with the new coordinator and explore ways to partner on an as needed basis.

//2012/The MCHB is working with the new staff at DHS to assure continued collaboration.//2012//

DHS Benefit, Employment and Support Services Division (BESSD) provides funding for Healthy Child Care Hawaii to the UH Department of Pediatrics. This collaborative project also involves the American Academy of Pediatrics-Hawaii Chapter and CSHNB. The project promotes the health and safety of young children in child care, based on the national health and safety performance standards in child care settings.

DHS Vocational Rehabilitation and Services for the Blind Division (DVR) is a state-federal program for individuals with disabilities which provides vocational rehabilitation services to enable eligible individuals with disabilities to achieve gainful employment and economic self-sufficiency. The Children with Special Health Needs Program refers clients as necessary for DVR services.

DHS Disability Determination Branch (DDB) which is part of DVR, determines whether Hawaii applicants for SSI disability benefits meet the required medical and/or psychiatric/psychological and vocational criteria to be found disabled. DDB refers children under age 16 years with disabilities who are medically eligible for Supplemental Security Income (SSI) to the Children with Special Health Needs Program (CSHNP). CSHNP provides outreach, assessment, information/referral, and/or service coordination as needed, regarding the SSI beneficiary's medical, education, and social needs.

MCHB collaboration with DHS programs includes child welfare/safety issues through projects like the Blueprint for Change, Title IVB Advisory groups, the Community Based Child Abuse

Prevention Program (CBCAP) and the Child Death Review. Due to the state RIF, MCHB is evaluating its current collaboration efforts to determine how best to utilize remaining staff and partnerships to achieve the desired outcomes for children and families.

Families that qualify for DHS services (the Supplemental Nutrition Assistance Program, formerly known as Food Stamp Program, TANF and Medicaid) are automatically income eligible for WIC. The agencies work closely to ensure clients receive information and assistance to apply for available services. DHS allows WIC limited computer access to the DHS enrollment system to check on adjunctive income eligibility for WIC applicants.

EXAMPLES OF PUBLIC AND PRIVATE COLLABORATION

Hawaii Early Intervention Coordinating Council (HEICC) advises the Director of Health on issues related to the planning, implementation, evaluation, and monitoring of the statewide system of early intervention services, and assists the DOH in achieving the full participation, coordination, and cooperation of all appropriate public agencies in the state. Members are appointed by the Governor and include parents of children with special needs, early intervention providers, state legislators, and representatives for personnel preparation, special education preschool services, Medicaid program, Office of the Governor, provision/payment of early intervention services, Head Start/Early Head Start, child care, foster care, regulation of health insurance, education of homeless children, children's mental health, family advocacy, military, and community preschools.

Newborn Metabolic Screening Advisory Committee consists of consumers and professionals from the private and public sectors, including physicians, laboratory personnel, nurses from various birthing facilities, medical insurance plan representatives, parents, and other DOH representatives. The committee's purpose is to provide support, guidance, and feedback to DOH about newborn screening; disseminate information about newborn screening to colleagues and the community; monitor accountability and quality of the newborn screening program; and discuss ideas and issues relevant to newborn screening.

Hawaii Birth Defects Program (HBDP) Advisory Committee is composed of representatives from the community, medical, university, and public and private sectors.

Early Hearing Detection and Intervention (EHDI) Advisory Committee advises the DOH Newborn Hearing Screening Program and its Baby Hearing Evaluation and Access to Resources and Services Project (Baby HEARS). The committee includes parents, AAP-Hawaii Chapter EHDI Champion, Hospital Newborn Hearing Screening Coordinator, DOH (EIS, Genetics Program, Newborn Metabolic Screening Program, and CSHNB Chief and Research Statistician), DOE (School of Deaf and Blind, Special Education), March of Dimes-Hawaii Chapter, Gallaudet University Regional Center, and pediatric audiologists.

State Genetics Advisory Committee consists of representatives from public health, health care organizations, consumers, laboratories, insurance, policy makers, and other interested organizations such as the March of Dimes. The Committee advises the DOH about genetics activities and helps disseminate information about these activities.

Hawaii Community Genetics (HCG) is a partnership of DOH/CSHNB Genetics Program, Kapiolani Medical Center for Women and Children, Queen's Medical Center, and UH School of Medicine to develop clinical genetics and metabolic services in Hawai'i. HCG has two full-time geneticists and one full-time genetic counselor for clinical services. Clinical genetics services are provided statewide with regular in-person Neighbor Island clinics and telemedicine visits. HCG also provides clinical and newborn screening follow-up services for Guam.

A core team of CSHNB, Family Voices (with the Hilopa'a Family to Family Health Information Center), UH/School of Medicine/Department of Pediatrics (with the Maternal and Child Health

Leadership Education in Neurodevelopmental and Related Disabilities), and American Academy of Pediatrics-Hawaii Chapter, with other key state/community partners, continues to work closely together in various areas toward achieving the six core outcomes for CSHCN.

The FHSD Medical Director is the Title V representative on the State Council on Developmental Disabilities. Act 175 of the 2001 Legislature required that the Council's membership include a Title V representative. The Council's responsibilities include: development of the state plan which guides the development and delivery of services for persons with developmental disabilities, coordination of departments and private agencies, evaluation, and advocacy.

The Special Education Advisory Council is an advisory committee to the Superintendent of Education for policies regarding the education of students with disabilities. Membership includes representative of consumer advocate groups, parents, individuals with disabilities, regular and special education personnel, DOH, DHS, and UH. EIS is a representative on SEAC.

The Early Childhood Comprehensive System (ECCS) Strategic Management Team (SMT) consists of public and private representatives charged with improving the system of early childhood services in the state. With a grant from the federal MCH Bureau, an assessment of the service system was completed and a strategic plan developed. The SMT provides leadership for the plan's implementation. Members include representatives from Departments of Education, Health, and Human Services, Department of Housing and Urban Development, Aloha United Way, American Academy of Pediatrics, Community Health Centers, Child Care Resource and Referral Agency, Good Beginnings Alliance, Hawaii Association for the Education of Young Children, Native Hawaiian Early Childhood Agencies, and parents.

Hawaii State Child Death Review Council is a voluntary public-private partnership formulated in 1996 through the leadership of Title V to establish a comprehensive, statewide, multidisciplinary child death review system to reduce preventable child deaths from birth to age 18. In 1997, state statute authorized the DOH to conduct child death reviews. The Child Death Review Council, with broad representation from the private and public sector, oversees the development and implementation of CDR.

Domestic Violence Fatality Review Council is a multidisciplinary and multiagency group of representatives from the public and private agencies which was legislated in 2006 to reduce the incidence of preventable deaths related to domestic violence. The DOH is the lead agency to administer statewide team reviews, to establish a surveillance system, to recommend changes in policy, organizational practice, community-based education, and interagency services, and to provide training opportunities.

Hawaii Children's Trust Fund (HCTF) was established by statute in 1993 to support family strengthening programs aimed at preventing child abuse and neglect and promoting healthy child development. HCTF is comprised of a coalition of parents, public and private agency personnel with an Advisory Committee and Board. The endowment fund consists of three streams of funding: federal funding from the Community-Based Child Abuse Prevention program (CBCAP), private donor contributions, and monies received from a tax check-off program.

Keiki Injury Prevention Coalition (KIPC) is an organization of over 60 private and public partners in the community, including neighbor island chapters. Title V staff participate in statewide activities to address issues related to childhood injury prevention. The Safe Sleep Committee, under the leadership of Title V staff, develops community-based prevention strategies. Title V is also active on the Suicide Prevention Steering Committee. KIPC supports networking with agencies and community organizations to effect legislation, policy, and educational measures to reduce injuries.

Hawaii Suicide Prevention Task Force (SPTF) was formed in 2005 and is staffed by the DOH Injury Prevention Program. The Steering Committee serves as an advisory group to the DOH and

works on implementing the goals and objectives for suicide prevention in the Hawaii Injury Prevention Plan. The SPTF consists of over 50 multi-disciplined, public and private agency members interested in suicide prevention. Members include the DOE, Honolulu Police Department's (HPD), the University of Hawaii, the Title V agency, DOH Child and Adult Mental Health Divisions, Emergency Medical Services (EMS) and others.

Child Safety Collaborative (CSC) is a public-private partnership to promote a safe and nurturing environment for children and youth. The group has defined "safe" to mean: free from environmental, physical, and emotional harm. The group works towards creating a child safety system that is coordinated, effective, and well-funded through public awareness, education, advocacy, and action. Primary partners include: Blueprint for Change, Department of Human Services, Good Beginnings Alliance, Hawaii Children's Trust Fund, Keiki Injury Prevention Coalition, Prevent Child Abuse Hawaii.

Child Abuse Prevention Planning (CAPP) Council is a public-private partnership that develops statewide public awareness events for the annual Child Abuse Prevention Month. Council members meet monthly and are represented by a broad spectrum of family strengthening and prevention organizations including all branches of the armed services. Council members develop a media campaign to share information about Child Abuse Prevent Month events.

Injury and Violence Prevention Cross-Program Integration Project is a joint effort between Hawaii DOH MCH Branch, Injury Prevention program and the Children's Safety Network (CSN). This 3 year pilot project will develop a toolkit and staff training to assist state MCH programs to effectively integrate injury prevention into their services. CSN is providing technical assistance and training for the project with a focus on prevention of child maltreatment and bullying.

Hawaii Partnerships to Prevent Underage Drinking (HPPUD) Coalition was created to coordinate efforts to address the problem of underage drinking in Hawaii. The members of the partnership represent county, state, and federal agencies, non-profit organizations, private businesses, and community residents concerned with the health of Hawaii's youth. The current structure of HPPUD includes a Statewide Advisory Council, and four county coalitions. HPPUD's Strategic Plan was completed in 2009.

Hawaii Perinatal Consortium (HPC) is a statewide leaders' forum organized to share information and data, define the unique needs of our state, and promote strategies to improve perinatal health. The HPC utilizes members' expertise to advance changes in health policy and public awareness through interaction with government, corporate, and community decision makers. HPC is an advisory group for policy development to interface with related coalitions and groups involved in perinatal health, provides a bridge for newly emerging issues, and assists organizations in data collection and presentation. Because of the MCHB reduction in workforce, staff maintain relationships with the various perinatal providers and convenes a Perinatal Advocacy Network that convenes statewide meetings at least annually to discuss perinatal issues and to network to share programmatic updates. The meeting is facilitated by Healthy Mothers Healthy Babies Coalition of Hawaii thru a contractual agreement.

Healthy Mothers, Healthy Babies Coalition of Hawaii (HMHB) is a nonprofit agency and part of a national network of organizations and individuals committed to improving maternal, child and family health through collaborative efforts in public education, advocacy, and collaboration. HMHB distributes educational materials for pregnant women and provides leadership for advocacy efforts by convening quarterly meetings of perinatal providers, disseminating regular news updates, and advocating for the adoption of important statutes and policies affecting perinatal health. HMHB oversees the Title V phone line MothersCare toll-free statewide hotline for information and referrals to prenatal care. HMHB also maintains a website that provides prenatal information and referral.

/2013/ In January 2012 Hawaii WIC started promoting TEXT4Baby, HMHB's mobile health technology education program for pregnant women and new moms.

//2013//

Healthy Youth Hawaii (HYH) is a state-wide coalition of leaders who share a concern about teen pregnancy. The HYH mission is "creating networks and promoting effective programs for Hawaii's youth that support healthy and informed choices". A primary goal is to actively promote the use of science-based, proven effective, and culturally appropriate teen pregnancy/STI/HIV prevention and sexuality health education programs for Hawaii youth. The Title X Family Planning Health Educator and the State Adolescent Health Coordinator of MCHB participate on this coalition.

Hawaii HIV/AIDS Community Planning Group (CPG) is a partnership between state health departments and community members who are infected with and affected by HIV. The primary task of the CPG is to work with the state health department to develop a Comprehensive HIV Prevention and Care Plan that is based on scientific evidence and community needs. The MCHB Title X Family Planning Health Educator is an elected member of this group.

Hawaii Women's Health Week Committee was established in 2006 to promote the importance of preventive screening and check-ups for women during Hawaii and National Women's Health Week and during the year. The Committee is comprised of Hawaii Department of Health, Kapiolani Women's Center; Healthy Mothers Healthy Babies Coalition of Hawaii; Hawaii Commission on the Status of Women; Women's Fund of Hawaii, American College of Obstetricians and Gynecology Hawaii Section, Planned Parenthood of Hawaii; and health plans including Hawaii Medical Service Association, AlohaCare, The Queens Women's Health Center; and Kaiser Permanente. It annually updates and distributes a screening guide and promotes other actions to promote preventive screening and check-ups for women statewide.

Adolescent Chlamydia Workgroup was established in 2004 to address this State priority and decrease Chlamydia rates for Hawaii youth. Public and private entities including the Department of Health, American College of Obstetricians and Gynecology and health plans Hawaii Medical Service Association, AlohaCare and UHAA are now focused on promoting strategies for increased screening and treatment of Chlamydia including partner management, and improving surveillance and data collection systems to support accurate reporting.

The USDA-FNS Hawaii Council is comprised of the U.S. Department of Agriculture (USDA) Field Office and USDA-funded State agencies (DOH WIC Program, Department of Labor & Industrial Relations Office of Consumer Services, DHS SNAP, University of Hawaii's Cooperative Extension Service and DOE Office of Hawaii Children Nutrition Programs). A memorandum of agreement supports collaboration between agencies to share goals and activities, implement culturally appropriate nutrition education materials and share resources.

The Hawaii Head Start-State Collaboration Project Advisory Council's mission is to assist the State of Hawaii in improving life outcomes and opportunities for Head Start-eligible families. The DOE, DHS, and the WIC Program are represented on the council. The seven priority areas of collaboration are: health care, welfare, child care, education, national service activities, family literacy services, and activities relating to children with disabilities.

The State Nutrition and Physical Activity Coalition (NPAC) was established to implement the State Nutrition & Physical Activity Plan. There are also neighbor island coalitions supported the DOH Healthy Hawaii initiative. The NPAC State Director is housed at the University School of Medicine. Several members of the Division are active in subcommittees addressing nutrition, school health, health services, workplace health, and the built environment.

Hawaii Immunization Coalition is a statewide, community-based coalition of public and private agencies, which ensures that all of Hawaii's residents are appropriately immunized against vaccine-preventable diseases. Activities include sharing information and resources, educational materials, policy development, and training for health professionals/organizations on current immunization information. Immunization practices to address access issues and barriers for at-

risk populations and data information systems continue to be priorities.

The Kona WIC Oral Health Project is a collaboration between the DOH Kona WIC Program, the West Hawaii Community Health Center and the Dental Health Foundation to increase accessibility to oral health services. WIC families will have oral screening, fluoride varnishes and education provided on-site.

/2013/ Hawaii WIC plans to expand the project to Hilo WIC or Maui WIC in late 2012. //2013//

The University of Hawaii Maternal Child Health Program, Department of Public Health, in the School of Medicine offered an MCH Certificate Program with federal MCH Bureau funding to provide training in data analysis and data-based program management. Several Title V agency staff have graduated from the certificate program. The MCH certificate program did not receive continued funding from MCHB, which will result in the closure of the only MCH public health training program in Hawaii and the Pacific. The program applied for a new MCH distance education grant. If awarded all coursework will be offered online.

/2012/ Notice of the DE grant award is still pending. One MCH course (MCH Policies and Programs) will be offered each Fall DE.//2012//

/2013/The DE grant was not funded and the program is now closed. The Title V program continues to collaborate with the MCH program faculty, currently utilizing faculty for technical assistance with a MCH Bureau TA grant to conduct program planning & skills building for the CSHN program. //2013//

F. Health Systems Capacity Indicators

The Health Systems Capacity Indicators (HSCI) measure the capacity of the system of care for the MCH population and the data capacity of the Title V agency to effectively monitor that status of the MCH population. The data is reported on Forms 17-19. Data was collected for most of the HSCIs with the exception of the SCHIP and Medicaid Linkage data that were not available. The Department of Health monitors trends in many of these HSCI indicators to inform programs and some will be discussed below.

DATA CAPACITY

HSCI 9# The ability of State to assure MCH program access to policy and program relevant information

This measure examines the Title V agency's capacity to access and utilize specific key MCH datasets.

DATA LINKAGE

Since 2001, Title V has used the State Systems Development Initiative (SSDI) grant to facilitate data linkage with birth certificate files and improve access to key MCH surveys/registries. Annual data linkage for infant birth and death certificates occurs at the DOH Office of Health Status Monitoring (OHSM), the vital statistics office. The Title V program has direct access to the linked database for analysis.

In 2004, the Children with Special Health Needs Branch (CSHNB) and OHSM began to link birth certificate files and newborn screening files for both newborn metabolic and hearing screening. Data linkage between birth certificates and WIC client files was achieved in 2007.

The only linkage that remains is between Medicaid and birth certificate datasets. Barriers to linkage include an out-of-state contractor that manages the Medicaid data system, loss of roughly half the agency staff in the 2009 state Reduction-In-Workforce action, a 13% enrollment increase due to the state recession and increased unemployment, a projected \$50M budget shortfall, and plans for changes to the eligibility system and benefit coverage necessitated by decreasing federal and state funding. As a critical partner to implement health care reform, Medicaid is also beginning work on improving health information technology and starting a Medicaid health home program. In 2008, Medicaid initiated an assessment of the current data system. It will likely be

sometime before data linkage can be seriously addressed. In the meantime, FHSD sought to identify alternative data sources.

A linkage between hospital discharge data with birth certificates could yield similar data results to a linked Medicaid dataset for Title V Medicaid comparison indicators (HSCI 5). The hospital dataset captures most births in the state including all Medicaid births. The dataset also captures all of the infant deaths in the state. Using SSDI funds, a membership was purchased to access statewide hospital/ER data from the Hawaii Health Information Corporation (HHIC), the non-profit corporation that collects inpatient discharge records for Hawaii's 23 acute care hospitals.

REGISTRIES AND SURVEYS

In the area of registries and surveys, FHSD has achieved direct access to all the electronic databases: PRAMS, birth defects surveillance, hospital discharge, and YRBS. PRAMS data is accessible via the DOH data warehouse website which provides pre-designed tables/charts on many of the PRAMS survey questions.

FHSD is focusing on rebuilding the capacity to collect birth defects data since the Hawaii Birth Defect Program transitioned from a program contracted through the University to a DOH program with state-funded staff under FHSD's CSHNB. Three positions are now filled with the remaining coordinator position still vacant. Data abstraction of records from births that occurred in 2006 have started.

FHSD has purchased data for HSCI 5a, and 5b from HHIC and are involved with a workgroup convened by the Director of Health to sustain direct access to hospital discharge records for the entire department.

FHSD has direct access to the Youth Behavioral Risk Survey (YRBS) dataset and sits on the School Health Survey Committee (SHSC) which oversees the administration of all school health surveys (including YRBS) in the state public school system.

FHSD continues to expand its epidemiology capacity to conduct analysis and publish findings to ensure MCH data is used for planning and policy development. In the past 2 years, FHSD has published 8 peer-reviewed State level manuscripts, 16 data reports, and numerous facts sheets and conference presentations using a variety of data sources.

MEDICAID AND CHILDREN

HSCI #7A: The percent of potentially Medicaid eligible children, aged 1 to 21 years, who have received a service paid by the Medicaid Program.

The Medicaid population has been shown in numerous studies to be of higher risk for many adverse outcomes and health risks. Partnership with Medicaid in Hawaii has occurred in the past and efforts to improve this relationship are ongoing including looking at various indicators and outcomes. Medicaid has seen significant increases in enrollment and cost-containment strategies that have been implemented include raising the eligibility threshold for adults, but pregnant women and children have not been directly impacted. It is anticipated that continued partnerships with Medicaid and with Community Health Centers will evolve under guidance related to health care reform.

In 2011, 44.4% of potentially Medicaid eligible children received a service paid by the Medicaid program which is consistent over the past 4 years where estimates have varied from 44.0% to 44.7%. The Title V agency's efforts to increase the percent of Medicaid-eligible children receiving a service paid by the Medicaid program are primarily enabling and infrastructure building services, conducted in partnership with other state and community agencies.

The Title V agency collaborates with the EPSDT program and the health plans contracted by Med-QUEST (MQD), the state Medicaid agency, to promote EPSDT. In addition, the Title V

agency's purchase-of-service contracts to community-based providers require enabling services which promote appropriate utilization of all health services, including Medicaid services. These contracts promote a system of care for vulnerable populations, which includes translation and case management services.

MQD has updated the EPSDT examination form, which includes immunizations, screening, referrals, and care coordination needs. The standardized form gives providers clear guidelines about the required examination components, and provides information on screenings and immunizations by various ages. The Title V agency provided input to MQD on this form. MQD is assuring diverse community participation and expert advising regarding EPSDT through methods such as topical meetings with specific stakeholders.

The MQD eliminated its EPSDT Coordinator position as part of the state reduction in workforce in October 2009. However, MQD continues to work with all health plans on two performance improvement projects: increasing access to care and reducing childhood obesity. To improve access to care, the Health Plan EPSDT Coordinators will continue to implement member outreach and provider training to support providers in meeting EPSDT goals. Outreach includes newsletters, and individual member reminder mailings. Delinquent letters are mailed when EPSDT visits are past due.

New software is being used to generate utilization reports for providers regarding preventive services. Health plans are exploring other methods to effectively target age groups such as an EPSDT health fair to improve utilization of preventive services.

HSCI #7B: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

The percent of children in the EPSDT program aged 6-9 years who received any dental services during the past year has increased over time with 62.1% in 2011, compared to 53.9% in 2009. Data comes from the Med-QUEST Division (MQD), the Medicaid agency in the State Department of Human Services (DHS), HCFA-416 Annual EPSDT Participation report. Low treatment rates have been the norm for the past ten years or more both in Hawaii and nationally.

For the second year Hawaii received an "F" from the PEW Trusts' States report card on children's oral health, meeting only 1 of the 8 policy benchmarks. The report grades states' ability to serve at-risk children using 8 evidence-based, cost-effective policies. The one benchmark Hawaii exceeded was the percentage of Medicaid-enrolled children who received dental care. In response to the failing grade, Title V in conjunction with the Primary Care Association, AAP-Hawaii, using a small Pew Foundation grant, convened a Children's Oral Health Summit in August 2011. The statewide video conference featured national pediatric dental speakers, policy and service program updates, and time for strategy identification. The Medicaid agency participated in the conference.

MQD, the Medicaid agency, provides dental services through a fee-for-service program that includes care coordination support to ensure that children from low-income families have access to essential dental care. Children under 21 years are eligible to receive comprehensive oral health services (Adults are limited to emergency and palliative care). MQD increased fees for selected procedures for Neighbor Island providers in accordance with state legislation. In 2007, MQD contracted with Cyrca Dental as its new Third Party Administrator for the dental program and, through Cyrca, decreased required paperwork and authorization requirements. Cyrca provides outreach and training for providers statewide. Cyrca also makes calls to all eligible children who have not had a dental visit in the last 12 months. Cyrca was also able to establish criteria and a fee schedule to repair cleft palate and an orthodontic fee schedule.

Strategies from the Children's Oral Health conference will focus on expansion of fluoride varnish applications by non-dental providers to at-risk young children; development and expansion of

hospital dentistry for CSHN and DD adults; increase public education on oral health; establishment of a data collection system; and expansion of service delivery methods (co-location of services, virtual dental offices).

Community Case Management Corporation (CCMC) is contracted by Cyrca Dental to facilitate statewide access to dental services. CCMC provides care coordination for recipients who need help accessing dentists on their home islands and arranges travel for neighbor island children and adults who require specialty care on Oahu.

CCMC works closely with the MQD staff who register all Medicaid providers. CCMC is informed when there is a new dentist and will inquire if a provider expresses interest in becoming a Medicaid provider or may have submitted an application. During the initial one to two year period after the neighbor island differential was established, no new providers signed on in response to the differential. New dental providers signed on in order to keep treating their patients who had lost their health insurance and became Medicaid recipients.

According to CCMC, there is an absence of Medicaid participating dental specialty care providers in sufficient number on all neighbor islands. In the last three to five years, a few new pedodontists have become available to serve the neighbor islands where previously there were none or access was extremely limited. This has helped address the demand for services. There are a number of dentists on all neighbor islands who serve the Medicaid population, but they will not necessarily take new patients or accept direct referrals from CCMC. The relatively low reimbursement rates and the negative "stereotype" of the Medicaid patient persist as barriers to additional participation. There is still a need to develop hospital-based treatment capacity on the island of Kauai. Recently, hospital-based care has become available on Maui, Kona, and Hilo. Although limited, it is available.

Each neighbor island county has established an oral health coalition and together they meet as a Tri-County Dental Task Force. Accessing dental services is more challenging on the rural neighbor islands since the highest concentration of dentists remain largely in urban Oahu. The Coalitions work to minimize off-island services through the expansion of local services. Because of the benefit structure, mainly children are flown to Oahu for dental care. CCMC is a sitting member of each county's respective dental task group and works with each group to try and help improve service access locally or improve coordination of services. Statewide utilization data gathered by CCMC is forwarded by Cyrca to the State. The data includes the number and cost of Medicaid enrollees that are flown to Oahu for oral health services.

The Title V Primary Care Office updates federal dental health shortage area designations and provides state dental health subsidies to the community health centers (CHC) for treatment services (subsidies cannot pay for preventive dental services). Of the 14 Federally Qualified Health Centers (FQHC), 12 provide dental services. Services for the uninsured are available on all the major islands through the CHCs or through partnerships with private dental provider (see NPM 9 narrative and attachment). The FQHCs have increased dental staffing, provided dental training through residency programs, and offered dental hygiene services. Also mobile dental services and outreach efforts were initiated to increase service accessibility. Community health centers on the neighbor islands are typically the single largest oral health provider of services to Medicaid recipients available. Consequently, CCMC receives a high volume of referrals from the FQHC's.

The DHD was the state's lead agency in children's oral health data. In August 2009, during the prior Administration, the DHD was eliminated as part of the state Reduction in Workforce action. All DHD dental hygienists services were eliminated including statewide oral screenings at public elementary schools. DOH continues to provide dental treatment services for eligible persons at 4 community-based dental clinics on Oahu and at Hawaii State Hospital. Comprehensive dental care is provided for persons with severe disabilities who are unable to access private sector services. Target populations include frail elderly and persons with chronic mental illness or

developmental disabilities.

DOH planning functions for oral health were recently transferred to the Title V agency. Title V is expected draw upon resources of the Offices of Primary Care and Rural Health to assist. A Division oral health workgroup has been convened that has met initially with Medicaid and its oral health contractors (CCMC) to identify areas for potential partnership including data sharing, policy development, and education/outreach. The workgroup also met with the Primary Care Association and has agreed to partner to convene the State Oral Health Task Force.

In an effort to increase data collection for oral health, the Title V agency will propose adding oral health questions to the bi-annual Youth Behavioral Risk Survey. A question about whether students had seen a dentist within the past year was included in the 2011 Hawaii Youth Tobacco Survey; 77.0% of middle school and 79.6% of high school students reported dental visits. The proposed YRBS questions will focus on whether students actually had experienced a dental problem (i.e. tooth ache, cavity).

Funding will be sought to support the inclusion of the questions in the 2013 survey.

Workgroup members recently viewed the Centers for Medicare & Medicaid Services (CMS) Learning Lab: Improving Oral Health Through Access, a series of webinars to provide technical assistance related to the CMS Oral Health Initiative. The workgroup will meet to consider the information provided and determine action steps. In August Title V will also receive technical assistance through a federal MCH Bureau request on oral health which should assist with planning efforts.

Another project Title V is supporting to help improve dental service utilization among young Medicaid insured children involves the co-location of oral health services at WIC offices. A pilot project was established in the Kona WIC office on the island of Hawaii. The project was initiated in conjunction with the West Hawaii Community Health Center (WHCHC) and the Hawaii Island Oral Health Coalition, with TA from the HRSA Region 9 Office. WHCHC sends a dentist and a hygienist to WIC (which provides space and makes appointments) for kids (0-5). Anticipatory guidance, oral health exams are conducted and fluoride varnish applied. Referrals are made to assure ongoing or follow-up care. WIC will evaluate the model of co-location of services for replication with other CHC partners. There are plans to expand the project to Hilo and Maui WIC office in late 2012-2013.

In response to the loss of the DOH dental hygiene program in the schools and to address findings from the Pew Report, the Maui Oral Health Task Force, Maui DOH District Health Office, Maui Oral Health Center at the University of Hawaii Maui campus are partnering with the Department of Education Maui District to do surveillance, provide dental screening, and oral health education to 3rd Graders in the Maui County.

For additional information on children's oral health initiatives see NPM 9 on dental sealants.

MEDICAID, PREGNANCY, AND BIRTH OUTCOMES:

HSCI #5: Comparison of Medicaid and non-Medicaid recipients prenatal access and birth outcomes are consistent with higher risks seen in those on Medicaid.

Hawaii has not yet adopted the 2003 revision of the birth certificate and does not collect information related to health insurance on the birth certificate. Thus, linkage to other sources of data is needed to identify risk among the Medicaid population. Medicaid linkage with vital statistics has not been achieved at this time, thus the data is not complete. Linkage efforts will continue through work funded by the MCH Bureau State Systems Development Initiative (SSDI) grant.

Thus, the Title V agency purchased data related to hospital discharge data of birth records using federal State System Development Initiative (SSDI) funds. The hospital data captures most births

in the state including all Medicaid births. Medicaid requires all deliveries to occur in hospitals. There are only about 200 home births annually which are not in this dataset. Title V has met with the Hawaii Health Information Corporation (HHIC) to explore the possibility of linking hospital infant delivery records with birth and infant death certificates. HHIC had conducted a feasibility study for this linkage in 2005 when the linked dataset was generated for a research project related to the costs of premature births. However, issues regarding HIPPA restrictions, administrative concerns, and cost need to be addressed for sustaining on-going linkage. This linkage may be more feasible than the linkage between birth and Medicaid records or implementation of a revised birth certificate.

Data for prenatal care utilization is available from the birth certificate but not in the Hospital discharge (HHIC) data. Due to the absence of birth certificate linkage to Medicaid data, data on prenatal care utilization is obtained from the Hawaii Pregnancy Risk Assessment Monitoring System (PRAMS) survey data funded by the Centers for Disease Control and Prevention. The PRAMS data is based on self-reported information obtained from a mailed survey with telephone follow up. Estimates for Medicaid service are based on insurance at delivery to match those obtained related to birth outcomes from HHIC data. This may actually over-estimate those actually on Medicaid during prenatal care, which is also compounded by a potential differential response to the survey from those of the lower incomes, and education levels that are more likely to be on Medicaid. As noted for linkage activities, potential linkage to the hospital discharge (HHIC) data may be a more appropriate measure of prenatal care utilization as captured in billing data.

In 2011, the proportion of births that were low birth weight (LBW) was higher in those on Medicaid (9.1%) compared to those not on Medicaid (8.1%). Similarly, the infant mortality rate (IMR) was higher among those on Medicaid (4.2 per 1,000 live births) compared to those not on Medicaid (3.5 per 1,000 live births). This differential based on Medicaid status has been consistent over the past several years.

In 2010, the proportion of live births to women on Medicaid who had prenatal care in the first trimester (77.5%) was significantly lower than those who were not on Medicaid (90.3%). Similarly, those on Medicaid (67.0%) were less likely to have an adequate level of prenatal care when compared to those not on Medicaid (72.5%). This differential based on Medicaid status has been consistent over the past several years.

Efforts are needed to continue to address the high risk Medicaid population as well as those that are uninsured including surveillance and building data capacity as well as partnering with service providers. Some activities that partner with service providers include early intervention services, perinatal support services, and community health centers.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Government Performance and Results Act (GPRA - Public Law 103-62) requires that each Federal agency establish performance measures that can be reported as part of the budgetary process that links funding decisions with performance and related outcome measures to see if there were improved outcomes for target populations.

In compliance with GPRA, the following progress report on the Title V Maternal and Child Health National and State Performance Measures is presented annually. The measures are reviewed by the Types of Service as shown in the pyramid in Figure 1. Specific program activities are described by the four service levels found in the MCH "pyramid" - direct health care, enabling, population-based, and infrastructure building services. Because of the flexibility inherent in the Block Grant, the program activities or the role that Title V plays in the implementation of each performance measure varies (i.e., monitor, advocate, provide, supplement, assure).

The goal for the state MCH agency is to focus on building the essential infrastructure services that assure an effective system of care exists to maintain the health of the MCH population.

Figure 2 presents schematically the Title V Block Grant Performance Measurement System designed to build state-level infrastructure capacity. The system begins with the assessment of needs, identification of priorities, program and resource allocation, tracking of performance measures, and culminates in improved outcomes for the Title V population.

The program activities, as measured by the National and State Performance measures, should positively impact the Outcome measures for the Title V population. While improvement in outcome measures is the long-term goal, more immediate success may be realized by a positive impact on the performance measures which are considered shorter term, intermediate, and precursors for the outcome measures. This is particularly important since there may be other significant factors outside of Title V programs that affect the outcome measures.

The performance measure system ensures fiscal accountability in three ways:

- 1) by measuring the progress towards successful achievement of the performance measures;
- 2) by having budgeted and expended dollars spread over the recognized MCH services: direct health care, enabling services, population-based services, and infrastructure building services, and eventually;
- 3) by having a positive impact on the outcome measures.

Based on a five year needs assessment, the State Title V agency identified seven priority health issues of unique concern to the State. Form 14 lists the current state priority health issues. A state performance measure is identified for those priorities that are not already associated with a national performance measure. Form 16 includes detail sheets on each of the unique state performance measures. Like the national performance measures, narrative reports are also presented for the state measures. Title V staff members from every branch in the Division work with agency and community partners over several months each year to compile the extensive program/service information and data required for the annual grant application and report.

Once submitted, the Block Grant application is subject to a standardized review process. The focus of the Review is on the progress being made by the State to meet its performance goals and to identify technical assistance that may be needed in order for the State to move towards achieving these goals.

An attachment is included in this section. IVA - Background and Overview

B. State Priorities

Through surveys of key stakeholders and partners and other communications related to the 2010 Maternal and Child Health five-year needs assessment process, priorities were established that the community and the Title V agency jointly identified as important and that are within their capability to address. Many issues were raised during the needs assessment process that affect the health and well being of the maternal-child health population that are beyond the scope of Title V services particularly during these times of state budget deficits.

The Title V Needs Assessment Steering Committee identified seven priorities. These priorities are the programmatic focus areas for FHSD work in partnership with other agencies/programs through 2015. Three priorities are continuing from the 2005 needs assessment: unintended pregnancy, child overweight (with a focus on early childhood), and alcohol use during pregnancy. Each priority is described in relationship to the National and State performance measures used to track them and are listed in no particular order. For a discussion of the capacity and resource capability of the State Title V program to address these priorities see the respective discussion under the performance measures listed below.

Priority 1. REDUCE THE RATE OF UNINTENDED PREGNANCY

The performance measures related to this priority are:

NPM 8 the rate of birth (per 1,000) for teenagers ages 15-17 years

SPM 1 The percent of pregnancies (live births, fetal deaths, abortions) that are unintended.

Priority 2. REDUCE THE RATE OF ALCOHOL USE DURING PREGNANCY

The performance measure related to this priority is:

SPM 2 Percent of women who report use of alcohol during pregnancy.

Priority 3. REDUCE THE RATE OF OVERWEIGHT AND OBESITY IN YOUNG CHILDREN AGES 0-5

The performance measure related to this priority is:

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.

/2012/Hawaii is using an existing NPM to measure a state priority, thus NPM14 is also used for SPM 4, the state measure created for this priority.//2012//

/2013/Hawaii has selected a new, unique state performance measure for this priority as required in the last Title V MCH Block grant review. SPM 8: Percentage of Hawaiian children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.//2013//

Priority 4. IMPROVE THE PERCENTAGE OF CHILDREN SCREENED EARLY AND CONTINUOUSLY AGE 0-5 FOR DEVELOPMENTAL DELAY

The performance measure related to this priority is:

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.

Priority 5. 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

The performance measure related to this priority is:

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

/2012/Hawaii is using an existing NPM to measure a state priority, thus NPM 6 is also used for

SPM 7, the state measure created for this priority. //2012//
/2013/ Hawaii has selected a new, unique state performance measure for this priority as required in the last Title V MCH Block grant review. 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. //2013//

Priority 6. REDUCE THE RATE OF CHILD ABUSE AND NEGLECT WITH SPECIAL ATTENTION ON AGES 0-5 YEARS

The performance measure related to this priority is:
 SPM 5 The Rate of confirmed child abuse/neglect reports per 1,000 for children aged 0 5 years.

Priority 7. PREVENT BULLYING BEHAVIOR AMONG CHILDREN WITH SPECIAL ATTENTION ON ADOLESCENTS AGE 11-18 YEARS

The performance measure related to this priority is:
 SPM 6 Percent of teenagers in grades 6 to 8 attending public schools who report bullying is a problem at their school.

C. National Performance Measures

Performance Measure 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.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	13	19	16	12	15
Denominator	13	19	16	12	15
Data Source		Hawaii NMSP	Hawaii NMSP	Hawaii NMSP	Hawaii NMSP
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2011

Data are from the State Newborn Metabolic Screening Program, Department of Health. The State of Hawaii tests for 32 disorders.

Notes - 2010

Data is from the State Newborn Metabolic Screening Program, Department of Health. The State of Hawaii tests for 32 disorders.

Notes - 2009

Data is from the State Newborn Metabolic Screening Program, Department of Health. The State of Hawaii tests for 32 disorders.

a. Last Year's Accomplishments

In FY 2011, 100 percent 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 (NBMSPP) is administered by Children with Special Health Needs Branch (CSHNB). NBMSPP has statewide responsibilities for assuring that all infants born in the state are tested for 32 disorders, meeting the national newborn screening recommendations from the American College of Medical Genetics and the March of Dimes for a uniform panel of 29 disorders. The most recent disorder added to the screening panel was cystic fibrosis (CF). Hawaii's contracted newborn screening laboratory, the Oregon State Public Health Laboratory, started testing for CF in September 2007.

The NBMSPP coordinator, the Registered Nurse IV and the Office Assistant position remained unfilled due to hiring freeze implemented by the Governor. The most essential functions of the program were maintained by staff from other CSHNB programs.

NBMSPP maintained oversight over the newborn metabolic screening system: obtaining blood specimens at hospitals, specimen transport, central laboratory testing, physician notification, and tracking. NBMSPP 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, NBMSPP identified the medical home, linked the medical home with the metabolic consultants, and followed-up with the medical home to ensure timely treatment.

NBMSPP funding is sustained through a \$55 fee assessed for each screening specimen collection kit. The fees are deposited in a state newborn metabolic screening special fund.

Monthly newborn metabolic screening practice profiles were sent to birthing facilities and submitters, in an effort to decrease errors in transit time, timing of specimen collection, specimen quality, and reporting of demographic information. Birthing facilities use these screening practice profiles as a quality assurance tool. Updated information on newborn metabolic screening is provided on the DOH website.

There were about 210 homebirths statewide in 2011. However, since the DOH Office of Health Status Monitoring (OHSM) (vital records) is not allowed to provide names of homebirths to NBMSPP, there is great potential for missed and/or delayed screening in this population. Packets with newborn metabolic screening and newborn hearing screening information have been distributed to birth registrars to give to homebirth parents when they register their infant for a birth certificate. To increase access to newborn screening for the homebirths, NBMSPP has been giving newborn screening specimen collection kits to midwives and naturopaths without charge.

NBMSPP continued to provide informational newborn screening brochure for parents through health providers statewide and provide follow-up for infants who did not receive newborn screening and are identified by "Specimen Not Obtained" forms and Hospital Monthly Newborn Screening Reports from birthing facilities.

NBMSPP continued to contract with the Hemoglobinopathy Clinic for confirmatory DNA alpha thalassemia testing to improve genetic counseling services to families. This analysis is needed for accurate alpha gene mutation information.

A "3 Part Metabolic Screening Project" was conducted as a pilot from July 7, 2011 and continued to January 20, 2012 in the Neonatal Intensive Care Unit (NICU) of Kapiolani Medical Center. The

purpose of the project was to assess the recommendation of the Clinical Laboratory and Standards Institute (CLSI) as it applies to Hawaii's population. The recommendation is to ensure early detection of disorders by obtaining blood spot specimens at certain time periods. Blood spots were collected on admission, between 25-54 hours of age and at 11-28 days of life. Conclusions drawn were that a 3 part screen did not increase detection rate, however, it did result in a higher number of false positive results.

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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract for confirmatory alpha thalassemia testing.	X		X	X
2. Contract for centralized newborn laboratory testing.			X	X
3. Contract for transport of specimens to centralized newborn screening testing laboratory.			X	X
4. Support genetics clinics for children with metabolic and hemoglobinopathy disorders.	X	X		X
5. Follow-up/track infants to assure satisfactory newborn screening; track abnormal and unsatisfactory screening results; track infants transferred and/or not screened.	X	X	X	X
6. Follow-up with medical home and medical specialists to ensure timely follow-up to definitive diagnosis and clinical management for infants with newborn screening disorders mandated by the State sponsored newborn screening program.	X	X		X
7. Update/distribute newborn metabolic screening brochure to birthing facilities and providers.			X	X
8. Update/distribute newborn screening practitioner's manual (guidelines) to primary care providers.			X	X
9. Conduct educational sessions for practitioners, nurses, laboratories, and birthing facilities.			X	X
10. Quality assurance with monthly screening practice profiles and immediate feedback on unsatisfactory specimens sent to birthing facilities/submitters.			X	X

b. Current Activities

Due to the lifting of the hiring freeze, the NBMSp coordinator position was filled in late October 2011 and the Office Assistant's position was filled in February 2012. The Registered Nurse IV limited term position remains vacant. This position has been difficult to fill as it has a temporary status. Plans are to request the position be changed to permanent status during the next Legislative session.

NBMSp continues oversight of the newborn screening system, sends out monthly screening practice profiles to birthing facilities, gives newborn screening kits to midwives and naturopaths at no charge, and funds the Hawaii Community Genetics clinic for metabolic disorders and Hemoglobinopathy Clinic services. CSHNB contributes services of genetic counselors, metabolic nutritionist, and NBMSp coordinator.

A Task Force was convened in April 2012 to address Critical Congenital Heart Disease (CCHD), which was added by the DHHS Secretary to the Recommended Uniform Panel of Disorders. The Task Force consisted of pediatric cardiologists, hospital representatives, community agencies, and parents. This was the first meeting to begin the discussion on possible implementation

issues. NBMSP will assist/support the hospitals as this program progresses.

The NBMSP Coordinator along with the Newborn Hearing Screening Coordinator began doing outreach activities together to birthing hospitals and midwives to provide training and updates to improve rates and accuracy of both screens.

c. Plan for the Coming Year

NBMSP will facilitate the processes needed to include CCHD in Hawaii's newborn screening panel. Activities will include:

- Researching cost involved in implementation. Third party payers need to be included in the discussion.
- Exploring the resources available on neighbor islands if a newborn screens positive.
- Developing a draft protocol for screening using the American Academy of Pediatrics protocol.
- Providing technical assistance to hospitals planning to implement.

Oregon plans to have screening available for Severe Combined Immunodeficiency Disease (SCID) in 2013. NBMSP will begin planning for the inclusion of SCID on the screening panel.

NBMSP Coordinator and Newborn Hearing Screening Coordinator will continue to provide outreach to birthing facilities, health care providers, public health nurses, childbirth educators and the general public to provide education, training and discussions of issues to improve screening and follow-up.

Because of the increasing number of home births (187 in 2004 to about 210 in 2011) without a concomitant increase in the percent screened (has been in the 70-80 percentile range), NBMSP Coordinator will provide increased outreach to midwives in person, in the Midwives Alliance of Hawaii newsletter and at the yearly conference to educate and encourage newborn screening for infants they deliver. NBMSP will continue to provide kits and support as needed.

NBMSP will continue to work closely with the contracted laboratory and medical consultants to streamline procedures of notification and follow-up of test results, linking the medical home with consultants to ensure timely treatment for infants confirmed with disorders.

NBMSP staff will continue to identify infants who did not receive newborn screening, based on "Specimen Not Obtained" forms and Hospital Monthly Newborn Screening Reports from birthing facilities, and will work with the birthing facilities to get these infants screened.

NBMSP will continue to emphasize quality assurance by assisting each birthing facility to improve their newborn screening practice profiles through monthly reports and in-service sessions and by providing immediate feedback on possible reasons for unsatisfactory specimens.

NBMSP will begin exploring such issues as developing emergency preparedness plans; developing long-term follow-up data; improving insurance coverage for metabolic formulas and medical foods for diagnosed metabolic patients; developing policies and procedures for electronic transmission of laboratory and demographic data to birthing facilities and laboratories; and developing policies and procedures for retention and use of residual dried blood spots.

NBMSP will continue to participate in HRSA's multi-state Western States Genetic Services Collaborative.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	19222					
Reporting Year:	2011					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	19155	99.7	6	1	1	100.0
Congenital Hypothyroidism (Classical)	19155	99.7	130	5	5	100.0
Galactosemia (Classical)	19155	99.7	46	0	0	
Sickle Cell Disease	19155	99.7	0	0	0	
Biotinidase Deficiency	19155	99.7	3	1	1	100.0
Congenital Adrenal Hyperplasia	19155	99.7	15	0	0	
Cystic Fibrosis	19155	99.7	44	2	2	100.0
msud	19155	99.7	1	0	0	
SCAD	19155	99.7	0	0	0	
VLCAD	19155	99.7	7	3	3	100.0
Methylmalonic Acidemia	19155	99.7	0	0	0	
Tyrosinemia, Type I, II	19155	99.7	1	0	0	
Carnitine Uptake/Carrier Defects	19155	99.7	0	0	0	
LCHAD	19155	99.7	0	0	0	
CPT I	19155	99.7	2	1	1	100.0
CPT II	19155	99.7	0	0	0	
Glutaric Acidemia/GA I	19155	99.7	1	1	1	100.0
Propionyl CoA Carboxylase Deficiency	19155	99.7	0	0	0	
Arginase Deficiency	19155	99.7	0	0	0	
Arginosuccinic Aciduria	19155	99.7	0	0	0	
Citrullinemia	19155	99.7	0	0	0	
Homocystinuria	19155	99.7	0	0	0	
Carnitine/Acylcarnitine Carrier Defect	19155	99.7	26	1	1	100.0
MAD/Glutamic Acidemia II	19155	99.7	0	0	0	
Isobutyryl CoA	19155	99.7	0	0	0	

Dehydrogenase Deficiency						
Multiple Carboxylase Deficiency	19155	99.7	0	0	0	

Performance Measure 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)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	52.5	59.3	59.3	59.3	62.5
Annual Indicator	59.3	59.3	59.3	59.3	77.6
Numerator	20783	20783	20783	20783	26502
Denominator	35041	35041	35041	35041	34131
Data Source		National CSHN survey	National CSHCN survey	National CSHCN survey	National CSHCN survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	82	82	82	82	82

Notes - 2011

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.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM #02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The annual performance objective for the years 2011 to 2015 was changed to reflect a 5 percent improvement from the 2010 annual indicator.

a. Last Year's Accomplishments

Families of children with special health care needs (CSHCN) were involved in decision-making in various ways: as advisory committee members; developing parent education materials; in presentations and panels; interviewing applicants for staff positions; advocacy for legislation; and

providing input on program policies and procedures. Parents were compensated or assisted by providing stipends, transportation and child care costs.

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

Early Intervention Section (EIS) supports families attending conferences and trainings by paying registration fees, airfare & ground transportation for Neighbor Island families to Oahu, and supporting child care during activities.

The Newborn Hearing Screening Program (NHSP) provides parent support to families with children who did not pass newborn hearing screening or who had confirmed hearing loss. Family members participate on the Early Hearing Detection and Intervention Advisory Committee. For the Parent Coordinator position for the Baby HEARS (Hearing Evaluation and Access to Resources and Services) Project, priority to hire is given to parent of a child with hearing loss. NHSP/Baby HEARS Follow-up Project provided a conference "Parent Power: Engaging Parents to Improve Outcomes for Children" for parents and professionals working with children with hearing loss and/or CSHCN. Topics included coaching families in the intervention process, adult learning styles, and parent coaching strategies.

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 family resource handbook in Children with Special Health Needs Program (CSHNP) includes a Transition section to develop a Family Individual Plan (FIP) for services. The Transition Checklist tool and FIP are developed together with children and their families. Plan components are reviewed annually with the family to address current and emerging concerns.

The Ho'opa'a Project--Hawaii Autism Spectrum Disorder (ASD) State Implementation Grant is a collaboration of Hawaii Pediatric Association Research and Education Foundation with Hilopa'a Family to Family Health Information Center (F2FHIC), Family Voices of Hawaii, DOH/CSHNB, American Academy of Pediatrics (AAP)-Hawaii Chapter, and UH Department of Pediatrics/MCH LEND (Leadership Education in Neurodevelopmental and Related Disabilities). Project goals/activities include expanding the F2FHIC to specialized parent support with culturally appropriate materials and providing families and professional partners with information on evidence-based best practices for ASD.

The F2FHIC provides information, education, training, outreach, and peer support to CSHCN families and professionals who serve them. "Veteran moms" assist families in finding or navigating community services for their children.

The Annual Big MAC (Moving Across Communities) Transition Fair was held for Maui special education students and their families with various community agencies and programs participating. Big MAC is a collaborative initiated through the Community Children's Council of Maui and the Maui Department of Education (DOE). At the Pacific Rim Conference on Disability and Diversity in Honolulu, Big MAC presenters including family leaders, shared strategies to build public-private collaborations supporting youth in their transitions across the community.

My Voice, My Choice (MVMC) project of the State Council on Developmental Disabilities, Hawaii Disability Rights Center, UH Center on Disability Studies and Self-Advocacy Advisory Council is a youth information, training, and resource center to improve education and employment outcomes

for youth by increasing their voice in development of policies and services that affect their choices. Youth and emerging leaders age 13 to 30 participated in MVMC activities throughout the state and the Youth Leadership Academy conference.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Involve family members in councils, task forces, and advisory and planning committees, in order to provide a parent perspective and support family-professional partnership.				X
2. Promote the inclusion of family members in planning and development of policy/procedures, program activities, review/revisions of parent materials, etc.				X
3. Obtain feedback from families on policy changes (e.g., administrative rules)				X
4. Support family participation in advisory meetings, conferences, workshops, etc., through providing travel support from Neighbor Islands, payment of conference registration fees, etc.				X
5. Involve family leaders in providing education/training from a parent perspective, such as presentation of family stories, participation on workshop panels, etc.				X
6. Employ parents as program/project staff, as possible, to provide a parent perspective to program development and in supporting families.		X		X
7. Provide information/training to families, providers, and programs on resources and services for CSHCN and on navigating the system of services.		X		X
8. Analyze and disseminate Hawaii data on family partnership from the National Survey of CSHCN.				X
9. Use Hawaii data on family partnership in planning/improving outcomes for CSHCN, developing/improving services, etc.				X
10.				

b. Current Activities

NHSP brought families and service providers together in conference "Shining the Light on Young Deaf, Hard of Hearing, and Deaf-Blind Children: Support Strategies for Families and Service Providers". Evidence based early experience and interaction strategies were provided to establish best learning foundations.

Youth Leadership Empowerment Academy gave participants an opportunity to focus on "we" rather than "I" and be empowered together in a communal effort to make a change. Self advocates spoke from personal experience on breaking down individual barriers in advocacy. They learned about self-advocacy and empowerment, and that together, they can empower each other to strive to reach their goals.

With CSHNP in leadership, Hawaii Island Kardiak Kids support group is active for children and parents. Resource reviews included Oahu Kapiolani Kardiak Kids parent support group and Kids camp, parents, friends, and youth with leadership potential. With grassroots family resources and support, members meet monthly. Teen mentorship club members provide positive peer support and speakers for community group events. Teens have their own officers and feel they have a chance to make an impact in their community. They are learning lifestyle management and arranging fun group outings.

Parent participation is an integral part of the Critical Congenital Heart Disease (CCHD) Task Force and NBMS Advisory Committee. Parent input is critical in exploring issues of adding CCHD to the screening panel.

c. Plan for the Coming Year

Families of CSHCN will continue to participate in decision making activities for programs and services in various ways. Participants are sought from diverse ethnic and cultural backgrounds.

Family members of CSHCN will continue to participate on the HEICC, NBMS Advisory Committee, Early Hearing Detection and Intervention Advisory Committee, State Genetics Advisory Committee, and WSGSC and its Family Advocate Work Group projects.

EIS will continue to support family participation in meetings, conferences, workshops, etc., through providing travel support from Neighbor Islands, payment of conference registration fees, etc. EIS will continue to obtain feedback from families on proposed administrative rules, such as through meetings or public hearings.

CSHNP activities for family involvement include using FIP and Transition Checklist with children and their families, supporting Hawaii Island Kardiac Kids peer support and mentoring project for adolescent concerns initiated by the West Hawaii CSHNP social worker, and obtaining family feedback in development of education materials and input on matters for partnership participation.

NHSP/Baby HEARS activities include improving follow-up for newborn hearing screening by hiring a Parent Support/Follow-up Coordinator to coordinate the services needed for infants who miss newborn screening or who are referred from newborn screening, and develop/revise parent educational pamphlets/fact sheets on hearing screening and hearing loss, with family input.

Ho'opa'a activities to support family-professional partnership include: continue F2FHIC specialized parent to parent support, information, and referral for families of children/youth with ASD; distribute culturally and linguistically appropriate materials for parents whose children have been newly diagnosed or may be new to the system; provide an annual ASD conference for families and professionals; coordinate and cross-promote Autism Awareness Month activities; update the "Rainbow Book -- A Medical Home Guide to Resources for CSHCN & Their Families", and provide training to professionals and families. The Project will continue to involve family members in presentations and panels at conferences and workshops.

The Title V Workgroups on early child development/screening and transition to adult health care will continue to develop and implement strategies and build community partnerships to improve access to these services for families. The groups will assist with updates for the Rainbow Book.

CSHNB will continue to track changes in state/community program services, legislation, and health insurance coverage that can impact CSHCN and their families.

CSHNB will continue to analyze and utilize Hawaii data on family partnership and other indicators from the National Surveys of CSHCN and Children's Health. The data will be used for CSHN program planning efforts supported a MCH Bureau TA grant to develop program logic models and identify clear outcome measures.

Performance Measure 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)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	47.9	45.2	45.2	45.2	47.5
Annual Indicator	45.2	45.2	45.2	45.2	45.4
Numerator	15632	15632	15632	15632	15157
Denominator	34568	34568	34568	34568	33383
Data Source		National CSHN survey	National CSHCN survey	National CSHCN survey	National CSHCN survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	48	48	48	48	48

Notes - 2011

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.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM #03. The annual performance objective for the years 2011 to 2015 was changed to reflect a 5 percent improvement from the 2010 annual indicator.

a. Last Year's Accomplishments

The medical home concept for all children, with and without special health care needs, has been promoted and supported by the American Academy of Pediatrics (AAP)-Hawaii Chapter, University of Hawaii (UH)/School of Medicine/Department of Pediatrics, DOH Family Health Services Division, and other public health programs.

Children with Special Health Needs Program (CSHNP) supports medical homes by assisting families with access to specialty services. It provides information and referral, outreach, service coordination, social work, and nutrition services for children with special health care needs (CSHCN) age 0-21 years. Pediatric cardiology, neurology, and nutrition clinics are provided in neighbor island districts where services are not available. CSHNP participates in the Kapiolani Medical Center Cleft and Craniofacial Center (KCCC) multidisciplinary team, works with families

and their medical homes, and assists with costs of neighbor island travel and orthodontic services. Financial assistance for medical specialty services is provided to eligible children who have no other resources. CSHNP provided technical assistance to 4 projects, 2 funded by Aloha United Way to screen preschool age children in 2 underserved communities, Lions Club screening school age children, and Public Health Nursing screening students in west Oahu. CSHNP provided Healthy Athlete Venue Directors and coordination of health screenings and education for Special Olympics. These projects refer children to their medical homes for follow-up.

Newborn metabolic and hearing screening programs include the medical home in their follow-up protocols. Newborn Metabolic Screening Program (NBMS) 'Hawaii Practitioner's Manual' is posted on the Hawaii genetics website and staff is available for consultation. Early intervention services, which include care coordination, involve the medical home in the Individual Family Support Plan (IFSP) conferences with family consent.

Other service coordinators for CSHCN and their families include Developmental Disabilities Division and Public Health Nursing Branch. Service coordination is a required component for Medicaid QUEST and Expanded Access (QExA) managed care for aged, blind, and disabled beneficiaries.

The Hilopa'a Project (May 2005-April 2009) promoted an integrated developmental screening and referral process in medical homes. The Project provided PEDS (Parents' Evaluation of Developmental Status) and ASQ (Ages and Stages Questionnaire) training for pediatric providers, with assistance of DOH/CSHNB Preschool Developmental Screening Program. The AAP-Hawaii Chapter supports pediatric providers performing developmental surveillance at every well child visit and using standardized screening tools at recommended visits or when concern is indicated.

Ho'opa'a Project -- Hawaii Autism Spectrum Disorders (ASD) State Implementation Grant is a collaboration of Hawaii Pediatric Association Research and Education Foundation with Hilopa'a Family to Family Health Information Center, Family Voices of Hawaii, DOH/Children with Special Health Needs Branch (Title V), AAP-Hawaii Chapter, and UH Department of Pediatrics/MCH LEND (Leadership Education in Neurodevelopmental and Related Disabilities) (Sept. 2010-Aug. 2013). The purpose is to improve comprehensive/coordinated health care and related services for children and youth with ASD and other developmental disabilities. A goal is to strengthen the medical home role in identifying and coordinating services for children and youth with ASD. Medical home activities include training medical home providers statewide on Modified Checklist for Autism in Toddlers (M-CHAT) screening tool and ASD referral algorithm.

The medical home is supported by work on issues of developmental screening and transition to adult health care, both selected state Title V priorities. Two Title V Workgroups working on these issues developed problem maps, fact sheets, and logic models.

Community health centers (CHC) strongly support the concept of patient-centered medical home and work toward coordinated integrated teams with health care professionals, support services to address socioeconomic factors, and other community providers. CHCs serve approximately 127,000 patients annually, nearly 10% of the state population.

Genetics program provided support for in-person neighbor island and telemedicine genetics consultations. Increased access allows the medical home to provide improved care for their patients.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Incorporate the medical home concept in direct/enabling services and in the planning/structure of CSHNB programs and services.	X	X	X	X
2. Analyze and disseminate Hawaii data on medical home from the National Survey of CSHCN and National Survey of Children's Health.				X
3. Use Hawaii data on medical home in developing and implementing plans to improve outcomes for CSHCN.				X
4. Promote developmental screening and follow-up. Provide information and support medical homes and other community providers in screening, appropriate referrals, and necessary follow-up.				X
5. Assist families of children in the Cleft & Craniofacial Clinic with coordinating services of community providers, promoting continuity of care and flow of communications, and providing information to community-based programs about the clinic.		X		
6. Continue collaboration and partnerships with other agencies and community-based organizations to promote/incorporate the medical home concept.				X
7. Improve coordinated services through the medical home for children and youth with ASD, through M-CHAT screening, appropriate referrals, and follow-up services.				X
8. Track the development/implementation of medical/health homes by health plans or organizations, community health centers, Medicaid, etc., and how CSHCN are impacted.				X
9.				
10.				

b. Current Activities

CSHNP, with Hawaii District FHSD Coordinator, expanded access to cardiology clinic services in West Hawaii, through transitioning CSHNP cardiac clinic (limited access) to a cardiac clinic (with wider community access) located at a community health center and supported in part by health insurance. A pediatric cardiologist continues to travel from Oahu and CSHNP social worker continues to support the clinic and medical homes of clients.

Ho'opa'a Project supports AAP-Hawaii Chapter activities to strengthen medical home screening, referral, and coordination of community-based services for children and youth. The project has had the M-CHAT translated into two Filipino dialects Tagalog and Ilocano, with Marshallese and Chuukese versions being finalized. Outreach to the Marshallese occurred through a Keiki (child) Health Fair held in a rural community of Ka'u on Hawaii island which has over 1,000 Marshallese migrants.

Ho'opa'a Project worked with EPSDT Coordinators to identify medical home providers who may not be providing the required developmental or ASD screening. Training/support and assistance in integrating screening into practice workflows is offered.

The AAP-Hawaii Chapter has a pediatric initiative for the patient-centered medical home. It includes seminars, surveys, small groups, projects, and resource information through Rainbow Book training.

The Genetics Program continues to provide support for in-person and telehealth neighbor island genetics consultations.

c. Plan for the Coming Year

CSHNB, Family Voices of Hawaii, AAP-Hawaii Chapter, UH Department of Pediatrics, and other organizations will continue to work toward accessible, family-centered, community-based, coordinated, comprehensive care through a medical home. The medical home concept will continue to be included in various planning efforts and program services for CSHNB, including CSHNP, newborn screening, early intervention, and genetics programs.

Various service coordinators will continue to serve CSHCN and their families, in coordination with medical homes. These include CSHNP service coordinators, Early Intervention care coordinators, Developmental Disabilities Division case managers, Public Health Nurses, and health plan service coordinators.

CSHNP will continue to support the medical home by coordinating services, assisting families with access to services, and assisting Neighbor Island children to obtain medical specialty services. CSHNP will continue working with the KCCC team, involving the medical home to assist families in coordinating treatment and related services.

Ho'opa'a Project will continue training on M-CHAT and referral/follow-up to support medical home screening/referral for ASD and other developmental delays, and integrating screening into practice workflows. Project updated the "Health and Related Services" section of the "Rainbow Book -- A Medical Home Guide to Resources for CSHCN & Their Families" to include various state/community health services. Rainbow Book training is being provided to physicians, nurses, social workers, care coordinators, and other state/community program staff statewide.

The Title V Workgroups on early child development/screening (see SPM #3) and transition to adult health care (see SPM #6) will continue their work in developing/implementing strategies, building community partnerships, and supporting with the medical home.

CSHNB will track the development/implementation of medical homes (also known as "patient-centered medical homes" or "patient-centered health homes") by health plans or organizations, community health centers, Medicaid, etc., and how CSHCN are impacted.

As it becomes available, CSHNB will begin analyze Hawaii data on medical home and other outcomes/indicators from the National Survey of CSHCN and National Survey of Children's Health. Data and information are used in reports, presentations, needs assessment, fact sheets, grant applications, program development, etc.

The genetics program is working with neighbor island medical homes to increase referrals for telehealth genetics consultations. The Western State Genetic Services Collaborative (WSGSC) is working with the local and regional medical home champions to improve primary care provider genetics education and ability to determine the need for a referral to a genetics specialist. WSGSC will continue to participate in the national HRSA efforts to integrate family history and genetics knowledge into medical homes.

Performance Measure 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)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	70.2	73.5	73.5	73.5	77.5
Annual Indicator	73.5	73.5	73.5	73.5	72.6
Numerator	26078	26078	26078	26078	24800
Denominator	35459	35459	35459	35459	34158

Data Source		National CSHN survey	National CSHCN survey	National CSHCN survey	National CSHCN survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	76	76	76	76	76

Notes - 2011

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.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM #04 indicator for both the 2001 and the 2005-2006 CSHCN survey. The annual performance objective for the years 2011 to 2015 was changed to reflect a 5 percent improvement from the 2010 annual indicator.

a. Last Year's Accomplishments

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

Children with Special Health Needs Program (CSHNP) service coordinators assisted CSHCN and their families to obtain and maximize use of health coverage from public and other sources. As a safety net and to increase access to services, CSHNP provided financial assistance for medical specialty, laboratory, x-ray, hearing aids, cardiac and neurology clinics on Neighbor Islands, and air/ground transportation for eligible families with no other resources. CSHNP administers the Hawaii Lions Foundation Uninsured/Under-Insured Fund for hearing and vision services.

CSHNP began exploring possibilities for extending the program's neighbor island Cardiac Clinic services into community partnership arrangements with use of third party benefits. This could expand access to children not participating in CSHNP who must travel to Honolulu for medical specialty services.

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

Early Intervention (EI) services for QUEST-eligible children are in part reimbursed under a Memorandum of Agreement (MOA) between the Department of Human Services (DHS) and DOH. EI services include assistive technology; audiology; family training, counseling, and home visits; health services; nursing; nutrition, occupational therapy; physical therapy; psychological services; service coordination; social work; special instruction; speech-language pathology services; transportation; and vision services. In 2009, bills to mandate insurance coverage of EI services were introduced but did not pass the state legislature.

Children with Special Health Needs Branch (CSHNB) with Family Voices State Coordinator facilitated the Autism Spectrum Disorders (ASD) Benefits and Coverage Task Force that was established by Act 221 of the 2008 state legislature. Task Force recommendations were in the areas of health insurance coverage for children with ASD (maximum benefit, treatment plan, services), coordination of health and community-based services, and family support. A July 2009 State Auditor report requested by the legislature did not support enactment of the legislative bill to cover diagnosis/treatment of ASD for individuals under age 21 since interventions were available through the Departments of Health and Education.

Ho'opa'a Project--Hawaii ASD State Implementation Grant is a collaboration of Hawaii Pediatric Association Research and Education Foundation with Hilopa'a Family to Family Health Information Center, Family Voices of Hawaii, DOH/CSHNB (Title V), AAP-Hawaii Chapter, and UH Department of Pediatrics/MCH LEND (Leadership Education in Neurodevelopmental and Related Disabilities) (Sept. 2010-Aug. 2013). The project purpose is to improve comprehensive/coordinated health care and related services for children and youth with ASD and other developmental disabilities. A goal is to develop a framework for integrated service planning and quality monitoring for Medicaid funded program services, with strategies focused on maximizing existing benefits.

Ho'opa'a Project worked with EPSDT Advisory Committee and EPSDT Coordinators to identify Medicaid providers who may not perform required developmental or ASD screening, provide training/support for the providers, and offer assistance in integrating screening into workflows.

CSHCN with family income up to 300% are eligible for Medicaid services under QUEST managed care or under QUEST Expanded Access (QExA) for individuals who are aged, blind, or disabled. QExA, which began in 2009, provides a comprehensive package of medical, dental, long-term care, and behavioral health care.

CSHNB is tracking insurance changes with health reform. A component of the Affordable Care Act (ACA) that supports the transition of youth with special health care needs to adult health care is the requirement for plans and issuers that offer dependent coverage to make the coverage available until the adult child reaches the age of 26 years.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide information and assist uninsured CSHCN/families in obtaining health insurance.		X		X
2. Provide information/assist CSHCN/families in accessing other public resources such as SSI and Medicaid services.		X		X
3. Provide or contract medical and other health services as a safety net for uninsured and underinsured CSHCN.	X	X		X
4. Identify and address issues and barriers that CSHCN/families have in accessing insurance/services to meet needs.				X
5. Support policy efforts to improve insurance coverage or				X

services for unmet needs such as Autism Spectrum Disorder.				
6. Disseminate Hawaii data on health insurance from the National Survey of CSHCN and National Survey of Children's Health.				X
7. Use Hawaii data on health insurance to develop and/or implement plans to improve outcomes for CSHCN.				X
8. Provide training to programs, agencies, providers and families on navigating the service system, including updated information on Medicaid program.				X
9. Track Hawaii legislation and support as appropriate health insurance changes that increase the access of CSHCN to needed services.				X
10. Track insurance changes with health reform and impact on CSHCN.				X

b. Current Activities

CSHNP, with Hawaii District FHSD Coordinator, is expanding access to pediatric cardiology clinic services in West Hawaii, through transitioning the CSHNP cardiac clinic (limited access) to a cardiac clinic (with wider community access) located at a community health center and supported in part by health insurance. On Kauai, CSHNP is transitioning its cardiac clinic children to a private pediatric cardiology clinic (with wider community access) supported by insurance.

CSHNB/Early Intervention Section worked closely with DHS /Med-QUEST Division to convert the existing capitated reimbursement system for EI services into a fee for service system. This involved explaining EI services, EI provider types, and establishing standard billing codes.

Ho'opa'a Project held an Autism Summit with community leaders in December 2011 on development of health care related policies/programs for CSHCN and/or ASD. Presentations included health care reform impact on ASD services, process to mandate coverage through Hawaii Prepaid Health Care Act, lessons learned from TRICARE Autism Services Demonstration, and perspective from Hawaii health plans.

The Genetics program with the multi-state Western States Genetic Services Collaborative and national efforts is also working on issues to improve coverage for medical foods/formulas for children with metabolic conditions. The Genetics program is also working with third party insurers to improve reimbursement for telehealth genetic consultations.

c. Plan for the Coming Year

CSHNB programs will keep actively informed about national health care reform, local initiatives, and study how changes in policy and practices affect children, families, and communities. Direct and enabling services will continue as a safety net, as well as activities and communications to increase access to services for the uninsured and underinsured. Staff will continue to provide information and assist uninsured families in obtaining Medicaid/QUEST and/or other health care coverage. Services and service planning with families will include information and education about health plans, consumer utilization, self advocacy, and resources.

CSHNP will continue efforts to work cooperatively with community health centers and local providers in extending pediatric specialty and related services and participating with community health service coordination.

Ho'opa'a Project will continue in providing training/support for EPSDT providers who may not be screening and will assist as needed in integrating screening into practice workflows. The Project has updated the "Health Coverage and Financing" section of the "Rainbow Book -- A Medical Home Guide to Resources for CSHCN & Their Families" to include health plans for children, Medicaid, insurance travel assistance, and Supplemental Security Income. Rainbow Book

training is being provided to physicians, nurses, social workers, care coordinators, and other state/community program staff, to assist them in better navigating and using the current system of services and resources. Training is being provided in various locations statewide.

CSHNB will continue to track Hawaii legislation and support as appropriate health insurance changes that increase the access of CSHCN to needed services. Legislative bills of the 2012 session that may be carried over to the 2013 session include mandated insurance coverage for ASD and for hearing aids.

CSHNB will continue to track insurance changes with health reform and how CSHCN in Hawaii are impacted.

CSHNB will continue to track health care benefits and related policies for impact to CSHCN and service systems. DHS is reducing the eligibility income limit for QUEST-ACE and QUEST-Net programs that offered limited health care benefits to non-disabled, non-pregnant adults less than 65 years old. Benefits for children will be maintained.

CSHNB will analyze Hawaii data on health insurance and other outcomes/indicators from the National Survey of CSHCN and National Survey of Children's Health. Data and information are used in reports, presentations, needs assessment, fact sheets, grant applications, program development, etc.

The Genetics program will continue to work with third party insurers to improve coverage for telehealth genetic consultations and improve coverage and reimbursement for medical foods and formula.

Performance Measure 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)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	69.2	88.8	88.8	88.8	93
Annual Indicator	88.8	88.8	88.8	88.8	71.5
Numerator	31708	31708	31708	31708	24616
Denominator	35713	35713	35713	35713	34430
Data Source		National CSHN survey	National CSHCN survey	National CSHCN survey	National CSHCN survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	75	75	75	75	75

Notes - 2011

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.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM #05. The annual performance objective for the years 2011 to 2015 was changed to reflect a 5 percent improvement from the 2010 annual indicator.

a. Last Year's Accomplishments

Children with Special Health Needs Branch (CSHNB) programs work toward coordinated, family-centered services/systems:

- Early Intervention Section is the lead for Part C of Individuals with Disabilities Education Act (IDEA) for early intervention (EI) services for children age 0-3 years with or at biological risk for developmental delays. The EI system includes central directory, public awareness, child find, evaluation/assessment procedures, Individual Family Support Plan, personnel development, procedural safeguards, complaint resolution, financial policies, and data collection.
- Newborn Hearing Screening Program is responsible for the statewide system of newborn hearing screening, including diagnostic audiological evaluation and link to EI services, technical assistance, quality assurance, data/tracking, and education.
- Newborn Metabolic Screening Program is responsible for the statewide system of newborn metabolic screening, including diagnosis and intervention/follow-up, data/tracking, quality assurance, and education.
- Children with Special Health Needs Program (CSHNP) provides medical specialty, nutrition, social work, pediatric cardiac and neurology clinics on Neighbor Islands (NI), outreach for children with Supplemental Security Income (SSI), and other services as a safety net and to increase access to services.
- Genetics Program and state/community partners work to assure the availability and accessibility of quality genetic services in the state.

Hawaii Community Genetics, a partnership of CSHNB Genetics Program, Kapiolani Medical Center, Queen's Medical Center, and UH School of Medicine/Pediatrics, provides clinical genetic/metabolic services, hemoglobinopathy clinic, neighbor island clinics, and telemedicine visits. Genetics Program hosted high school students and their teachers at Hawaii DNA Activity Day 2011, with forensic experts and hands-on activities. Activities to improve access to genetic services for neighbor island families are continuing with WSGSC (Western States Genetic Services Collaborative) projects evaluating various approaches.

Neurotrauma Supports, in DOH/Developmental Disabilities Division, addresses needs of brain-injured persons and their families. Activities include statewide telephone Helpline, assisting survivors/families to identify and access services, providing education /public awareness, and Peer Mentoring project. CSHNB is a member of the State Traumatic Brain Injury Advisory Board.

Family Health Services Division (FHSD) coordinates the Fetal Alcohol Spectrum Disorder (FASD) Task Force for development of a comprehensive statewide system for prevention, identification,

surveillance, and treatment of FASD. Training is provided for community providers and programs.

CSHNP staff participates as multidisciplinary team members for the Kapiolani Cleft and Craniofacial Center (KCCC) at Kapiolani Medical Center for Women and Children. KCCC serves over 300 children/youth up to age 18 years. KCCC has met Cleft Palate Team standards established by American Cleft Palate-Craniofacial Association/Cleft Palate Foundation. Team includes craniofacial surgeon, neonatologist/pediatrician, geneticist, genetic counselor, audiologist, speech therapist, pediatric dentist, oral surgeon, orthodontist, and other specialists. CSHNP Nurse and Social Worker provide service coordination and assist families in identifying needs/resources, referrals to community programs, and accessing specialized dental/orthodontic treatment services.

The issues of early childhood development/screening and transition to adult health care were selected as state Title V priorities. Two Title V Workgroups are working on system-building for these issues and had developed problem maps, fact sheets, and logic models.

Ho'opa'a Project--Hawaii Autism Spectrum Disorder (ASD) State Implementation Grant is a collaboration of Hawaii Pediatric Association Research and Education Foundation with Hilopa'a Family to Family Health Information Center, Family Voices of Hawaii, DOH/CSHNB, AAP-Hawaii Chapter, and UH Department of Pediatrics/MCH LEND (Leadership Education in Neurodevelopmental and Related Disabilities) (Sept. 2010-Aug. 2013). Project activities focus on improving/strengthening the system of care for children/youth with ASD and other developmental disabilities in areas of family support, medical home, autism screening, insurance coverage, and information/training on evidence-based practices, community resources, and transition.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide medical specialty and other services as a safety net for CSHCN who have no other resources, and to increase access to services.	X	X		X
2. Improve coordination of health, education, social, and other services for CSHCN.		X		X
3. Provide education/training on services/resources for CSHCN and navigating the system of services.				X
4. Establish and maintain collaborative partnerships on system-building efforts that will improve outcomes or access to services for CSHCN.				X
5. Disseminate Hawaii data on health and services system issues from the National Survey of CSHCN and National Survey of Children's Health.				X
6. Use Hawaii data and information on the current service system and resources identified through Title V needs assessment to develop/implement collaborative strategies toward improving health outcomes for CSHCN.				X
7. Track Hawaii legislation on health insurance and medical/health home initiatives that increase the access of CSHCN to needed services				X
8. Track insurance and medical home changes with health reform and impact on CSHCN.				X
9.				
10.				

b. Current Activities

With the Hawaii District Office FHSD Coordinator, CSHNP expanded access to pediatric cardiology clinic services in West Hawaii, by transitioning the CSHNP cardiac clinic (limited access) to a cardiac clinic (with wider community access) located at a community health center, supported in part by health insurance. This contributes to increasing access to specialty care and related services.

Genetics Program with the Western State Genetic Services Collaborative developed a Portable Health Record (PHR) for use by people with genetic or metabolic conditions in times of transition or emergencies. The Genetics program continued to increase access to genetic services statewide via in-person and telehealth clinics.

Ho'opa'a Project supported AAP-Hawaii activities to strengthen medical home identification, referral, and coordination of community based services for children and youth suspected or with special health needs. Other Project activities include providing training/support on developmental or ASD screening and offering to assist in integrating screening into practice workflows.

CSHNP explored concerns of parents with children of divorce, when the parent providing health coverage is feared and that coverage and specialist/provider are not utilized. The extent of the problem, options for service access, effect on the child's condition, options the parent may seek and implications, and program services will be reviewed with related community agencies and recommendations developed.

c. Plan for the Coming Year

CSHNB programs will continue system-building efforts to address access to services, provide education/training, promote family-professional partnership, improve coordination of services, and address changes to the health care delivery system.

CSHNP will continue to collaborate with community partners regarding access to services. CSHNP will continue to support the recent transition of CSHNP cardiac clinic to a clinic located at a community health center in Kona that is partly supported by health insurance. On Kauai, CSHNP is transitioning children attending the CSHNP cardiac clinic to a private pediatric cardiology clinic supported by insurance. In both areas, involvement and services of CSHNP workers when needed, will continue in home and community.

Title V priority issue workgroups on early childhood development/screening and transition to adult health care will continue updating information on existing services and resources, identifying key partnerships, and developing/implementing collaborative strategies.

With the FHSD support, the FASD Task Force will continue to facilitate development of a statewide system for the prevention, identification, surveillance, and treatment of FASD. Activities include FASD awareness and training; mobilizing and coordinating state/community resources; and improving service delivery for individuals/families affected by FASD.

The Genetics Program with WSGSC will continue analyses and maximize efficacy of outreach and telemedicine services to distant areas. Participation with medical home and MCH LEND will continue. Resources and activities needed to collect long-term follow-up data for newborns will be explored.

The Ho'opa'a Project will continue activities including training on ASD screening and referral, service coordination, transition, and community resources, educational conferences; and public awareness. The Project has updated the "Rainbow Book -- A Medical Home Guide to Resources for CSHCN & Their Families", and is providing training to health care professionals and state/community program staff statewide.

CSHNB staff will continue to participate in various system-building efforts, including Health and

Early Childhood committee of the State Council on Developmental Disabilities, Keiki Injury Prevention Coalition, State Traumatic Brain Injury Advisory Board, and Emergency Preparedness Special Initiative focused on persons with intellectual/developmental disabilities.

CSHNB will continue to track Hawaii legislation related to health insurance or medical home that impacts the access of CSHCN to needed services. CSHNB will also track insurance changes with health reform and how CSHCN in Hawaii are impacted.

CSHNB will analyze Hawaii data on service system and other indicators from the National Survey of CSHCN and National Survey of Children's Health. Data are used in reports, presentations, needs assessment, fact sheets, grant applications, program development, etc.

Performance Measure 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.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	5.1	39.4	39.4	39.4	42
Annual Indicator	39.4	39.4	39.4	39.4	37.3
Numerator	5024	5024	5024	5024	4714
Denominator	12766	12766	12766	12766	12643
Data Source		National CSHN survey	National CSHCN survey	National CSHCN survey	National CSHCN survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	40	40	40	40	40

Notes - 2011

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.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for NPM #06 and the 2005-2006 may be considered baseline data. The annual performance objective for the years 2011 to 2015 was changed to reflect a 5 percent improvement from the 2010 annual indicator.

a. Last Year's Accomplishments

The foundation for transition begins in early childhood. The DOH CSHN Branch (CSHNB) Early Intervention Section (EIS) provides planning and support for children with developmental delays exiting from early intervention (EI) services and transitioning to the Department of Education (DOE) preschool special education or other appropriate services. In 2011, EIS held a 4-day intensive transition training and invited other community agencies to participate.

As a graduation requirement, all DOE public school students developed a personal plan to support their transition from school to post-secondary education/career. Students receiving special education are required to have an Individual Education Plan (IEP). For the 2009-2010 school year 76% of youth aged 16 and above had an IEP that included measurable postsecondary goals. The goal for school year 2010-2011 was 100%.

EPIC Ohana is contracted by the State Department of Human Services to administer the Youth Circles program for those aging out of foster care. This youth-driven, strength-based process helps foster care teens reach their transition goals. The Hawaii Youth Opportunities Initiative (HYOI) was formed to raise awareness of youth who "age out" of foster care & provides access to necessary supports for successful transition.

Family Programs Hawaii (FPH) provides services to prevent children from entering the foster care system, provides supports to children/families in the system, and assists foster youth with transitioning out of this system.

In 2010, Transition Aged Youth (TAY) Task Force was reconvened after the suicide of an 18 year old who had recently left the foster care system. Discussions centered around services for youth exiting foster care, particularly the loss of health insurance coverage when youth age-out. The Medicaid agency was aware of the problem and worked to streamline the transition process to adult health care coverage. A social worker from FPH chaired the TAY Task Force.

CSHNP continued its outreach services to medically eligible Supplemental Security Income (SSI) applicants less than 16 years of age. Assessment, information and referral, guidance to access services, and transition planning are provided as needed.

The Ho'opa'a Project-Autism Spectrum Disorders State Implementation Grant, a collaboration of Family Voices, CSHNB, American Academy of Pediatrics-Hawaii Chapter, and University of Hawaii/School of Medicine-Department of Pediatrics, was awarded to Hawaii by the federal MCH Bureau. Plans for an updated State/Community Resource Guide, "Rainbow Book," included a new chapter on Autism and updates for the Transition Planning chapter. The Guide was developed through an earlier MCH Bureau systems integration grant for CSHCN.

The Ho'opa'a Project presented a session on "Making the Transition to Adulthood for Patients with Autism Spectrum Disorders (ASD)" at the April 2011 American Academy of Pediatrics-Hawaii Chapter conference.

In February 2011, the Maui DOE, the Developmental Disability Council and other agencies, held the third Big MAC (Moving Across Communities) Transition Fair for students in special education and their families. The Hilopa'a Family to Family Health Information Center (HFFHIC) coordinator did a presentation on "Transition to Adult Life," and shared resources including a Transition

Workbook and Personal Health Record. Over 20 local and state agencies (including the Title V CSHNP) hosted information booths. Given the success of the conference, Big MAC coordinators spoke at the statewide Pacific Rim Disabilities Conference in April 2011 to encourage other DOE districts to hold similar transition fairs.

CSHNP convened a Title V Transition Workgroup and incorporated transition planning into standard program practices with families. The Workgroup continues to network/education with other programs serving youth with special health care needs (YSHCN) on transition planning. Members met with the new Adult Congenital Heart Clinic staff to discuss transition planning and provide them with transition materials. The Workgroup developed a user-friendly "Footsteps to Transition" flyer for YSHCN and their families. The flyer was field-tested at informational events (Maui Big MAC and Special Olympics) and with CSHNP families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate transition planning resource materials for Youth with Special Healthcare Needs (YSHCN) and their families including the Hilopa'a Transition Workbook, Personal Health Record, and "Footsteps to Transition".				X
2. Develop transition planning informational materials for consumers and service providers to assure transition planning support is provided to YSHCN and their families				X
3. Document, in the Rainbow Book Resource Guide, the best practices, protocols, and standards for coordinated care, including transition, between programs and agencies that serve children and youth with special health care needs.				X
4. Provide training on the Rainbow Book Resource Guide which includes information on transition services, to physicians, health care providers, and agencies that serve YSHCN and their families.				X
5. Incorporate transition planning into policy and procedures, and provide staff training for Title V CSHN Program and Early Intervention Services.		X		X
6. Partner with the State Department of Education to support greater integration of transition planning information and services to student in public schools, with particular attention to Special Education students and their families.		X		X
7. Analyze/review existing data sources on transition planning and identify new data sources to identify needs, monitor progress and evaluate services.				X
8. Promote the importance of transition planning through community fairs, conferences, and at regular community and agency meetings.				X
9. Assess potential benefits of the federal Affordable Care Act to support transition planning				X
10.				

b. Current Activities

EIS continues to include transition in staff/provider trainings. Transition and support services for foster care youth continue. HYOI expanded services to foster care youth to East Hawaii Island. The Medicaid agency revised procedures so youth aging out of foster care will have greater support to access medical coverage as adults.

The Hawaii Department of Labor and Industrial Relations Workforce Development Division (WDD) supports "One Stop Centers" with free assistance to apply for education, employment, and training opportunities.

The 4th annual Maui and first Kauai DOE Transition Fairs were held. Community groups shared information with special education youth and families. Title V staff worked in conjunction with the state Medicaid agency and the HFFHIC, to conduct health fairs in Ka'u, a rural Hawaii Island community, targeted to the large Micronesian/Marshallese population. Information was provided on transition. The West Hawaii Kardiac Kids support group promotes transition for youth with cardiac conditions to adult health care. Their website offers critical information to facilitate transition.

The Ho'opa'a Project released the 2012 Rainbow Book Resource Guide, which includes a chapter on transition planning. Statewide trainings on the Guide are free. Monthly webinar trainings on the Guide have been integrated into a pilot Medical Home Project for primary care physicians sponsored by the State's largest health insurer. One webinar will be dedicated to transition services.

c. Plan for the Coming Year

EIS will continue to support the transition of children from EI to DOE and continue transition training for EI and other community staff. The DOE Sequenced Transition to Education in Public Schools (STEPS) team sponsors trainings and health fairs across the state. This team supports a seamless transition system for children, prenatal to grade three, with an emphasis on successful transitioning into kindergarten.

DOE Special Education services will continue efforts toward meeting its 2011-2012 objective to have 100% of youth age 16 and older have an Individual Education Plan (IEP) that includes appropriate measurable postsecondary goals. The DOE has a project targeting middle and high school students to increase their self-advocacy and self-determination skills. The Children's Community Council (CCC) and school complex transition personnel are exploring the potential of conducting more island/district transition fairs. The CCC is a partnership of parents, school personnel, private providers and other community members that provides community-based planning and evaluation, provides support and training to parents of special needs children, identifies gaps in service delivery and offers possible solutions, and provides system advocacy to support and maintain the quality of services needed in the local community.

The Title V Transition Workgroup continues to identify strategies to increase collaboration and service integration among agencies to improve transition planning for YSHCN and their families. A new partner is the state youth correctional program that is interested in developing a mini-transition Resource Guide for youth exiting their facility. The Workgroup will continue to strengthen its partnerships with the DOE since it serves many of the YSHCN in the state public school system. Workgroup activities will also focus on reviewing existing transition data to improve assessment and evaluate progress to improve the availability of transition planning services for YSHCN and their families.

The Affordable Care Act allows young adults to stay on their parents' health care plan until age 26, by requiring health plans and issuers that offer coverage to children on their parents' plan to make the coverage available until the adult child reaches the age of 26. Health insurance coverage supports youth in their transition to adult health care.

CSHNP social workers and other professional staff will continue to provide outreach services and transition information to medically eligible SSI applicants.

Child and Adolescent Mental Health Division (CAMHD) will continue using the Coordinated Service Plan (CSP) to plan strategies that support the youth achieving his/her goals. The Mental

Health Transformation Grant helped sponsor the Network of Care, an online resource for those concerned with behavioral health, that can help people find services, interact with others, and store medical/service information that may be useful for transitioning youth.

Performance Measure 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.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	84.8	86.6	88.3	90	91.7
Annual Indicator	87.8	78.3	66.9	66.3	66.3
Numerator					
Denominator					
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	70	70	70	70	70

Notes - 2011

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.

Notes - 2010

Data on immunization series 4:3:1:3:3 comes from the U.S. National Immunization Survey (NIS), CDC. Because of the addition of the varicella vaccine the 4:3:1:3:3 data series is slightly different than in previous years.

The 4:3:1:3:3 series coverage is based on the original definition for this series. CDC made this series coverage available in the 2009 web tables and prior but not 2010; it is not recommended for comparison to years prior to 2009 because of the changes made in the way the Hib vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples. Recognizing that some state grantees use this 4:3:1:3:3

measure, the CDC will be including it in future releases of the NIS data on the CDC website. In the future, coverage estimates will be based on the new definition for Hib that takes into consideration the vaccine brand type (i.e. some children only need 3 doses to be up to date, while others need 4 doses to be up to date), this began with the 2009 data.

Notes - 2009

Data on immunization series 4:3:1:3:3 comes from the U.S. National Immunization Survey (NIS), CDC. The survey reports the percentage of estimated state vaccination coverage, but does not provide the numerators and denominators used in the calculations. The estimate for the 2009 is not available at time of this report so the 2008 estimate was carried forward. The annual performance objectives have been modified to meet 90% by 2010. Subsequent objectives were set to increase at the same increment annually.

a. Last Year's Accomplishments

Data from the 2010 National Immunization Survey indicate that 66.3% of children ages 19-35 months have completed the recommended schedule of immunizations in Hawaii (the latest available data). The annual State objective was not met, nor was the HP 2020 goal of 80%. The 2010 State indicator compares well to the 2010 national rate of 60.6%. There could be many factors influencing this decline and discussions with the DOH Immunization Branch suggested that the decrease in immunization rate in 2009 may be due to the shortage of Hib vaccines during December 2007 to September 2009. Another factor may have been related to the H1N1 vaccination campaigns and the increase number of immunizations required which may have resulted in delaying of other required immunizations to minimize the total number received in particular visits.

The DOH Immunization Branch, which is the lead agency for children's immunization, administers state and federally funded vaccine programs, provides information on immunization schedules, vaccination availability, and immunization policies and works to promote collaboration.

The Title V agency assures health care providers monitor and track whether children served are receiving immunization through service contracts or direct service provision. Community Health Centers (CHC), Healthy Start, and WIC programs provide infant immunization education and referrals as part of their services. The CHCs and the Healthy Start program collect data on immunization rates for children to assure completion of the full schedule of vaccines.

The federally funded Healthy Start Big Island Perinatal Health Disparities program (BIPHDP) employs Neighborhood Women to conduct community outreach and provide perinatal support services to high-risk pregnant women on the island of Hawaii. Target populations include women of Hawaiian, Other Pacific Islander, Hispanic, and Filipino ancestry and adolescents. Services continue for two years during the interconception period and include promoting well child care, case management, and immunizations.

The Hawaii Immunization Coalition (HIC) is a statewide non-profit coalition of public/private organizations and concerned individuals whose mission is to promote effective strategies to ensure that all of Hawaii's families are appropriately vaccinated against vaccine-preventable diseases primarily through building partnerships, advocacy, training for service providers, and public education and outreach. HIC members address issues across the lifespan through infant, adolescent and adult work teams to improve immunization rates for these target populations.

A draft of the HIC 5 Year Strategic Plan was released. The goals include immunization policies and advocacy, training, increasing public awareness, promotion of the HIC website and social marketing activities. The HIC sponsored a presentation on Immunization against Pertussis in November 2010. An ad hoc team will begin working on pertussis strategies in May 2011.

The Public Health Nursing (PHN) Branch conducts immunization clinics for the uninsured and underinsured at statewide PHN sites. The PHN immunization clinics provide accessible services

to the immigrant population and the underinsured.

The Vaccine for Children (VFC) program provides immunizations to the uninsured, underinsured, American Indian, Alaskan Native and Medicaid children from birth to 18 years old through CHCs, rural health clinics, PHN immunization clinics, and participating primary health care providers statewide.

Healthy Mothers, Healthy Babies (HMHB) Coalition of Hawaii provides system building support to improve statewide perinatal services. HMHB manages the pregnancy resource, referral, information phoneline, "Text4baby", and website which include a parent guideline to childhood immunizations. Women who enroll in "Text4baby" services receive weekly text messages during pregnancies and through their babies first year. "Text4baby" transmits a message encouraging parents to schedule well child visits.

DOH Immunization Branch implemented the Hawaii Immunization Registry (HIR). Beginning February 2011, all publically funded vaccine doses administered were included in the HIR. The Hawaii Immunization Branch continues to recruit, enroll, and train providers on all islands to participate and submit data to the HIR. In August 2011, the Immunization Branch coordinated Centers for Disease Control and Prevention Immunization update course for health care providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide immunizations for the under- and uninsured children at statewide clinics and community health centers.	X			
2. Provide referral and follow-up on immunizations for low income mothers through MCH programs.		X		
3. Provide education and outreach to at risk families of young children at community health centers.		X		
4. Provide education and outreach to promote immunization awareness.			X	
5. Support collaboration among agencies/programs to improve child immunization rates.				X
6. Develop and advocate for policies to support increased immunizations among children.				X
7. Monitor immunization rates.				X
8. Continue with the implementation of a statewide immunization registry.				X
9.				
10.				

b. Current Activities

The CHCs, Healthy Start, BIPHDP, and WIC programs continue providing immunization education, referrals to services, and collect data on immunization rates.

The VFC program implemented by the PHN immunization clinics, CHCs, rural health clinics and participating health care providers continues.

The Immunization Branch plans to work on increasing pertussis immunizations for post-partum women, children and adults, and those in close contacts with infants. A pertussis campaign will be implemented in 2012 and focus on protecting infants by vaccinating parents and close contacts of infants. Website, internet marketing, and print materials will be used to disseminate information.

Immunization Branch received a CDC grant to improve the HIR's ability to order vaccines through the CDC national vaccine order and tracking system and interface with physicians' electronic health records (EHR) to exchange vaccine information between HIR and HER. As of April 29, 2012, there were 462,410 patients and 1,034,893 immunizations recorded in HIR.

The Hawaii Hepatitis B Perinatal Prevention Program continues to provide Hepatitis B vaccines at no cost to newborn infants at all Hawaii delivery hospitals. The program also tracks and manages infants born to HBsAG positive women and contacts of identified HBsAG positive pregnant women.

In May 2012, Immunization Branch is sponsoring an 'Ask the Local Expert" session on vaccine storage and handling for VFC providers.

c. Plan for the Coming Year

The annual performance objective for the years 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011 annual indicator.

The VFC program implemented by the Public Health Nursing immunization clinics, CHCs, rural health clinics and participating health care providers is ongoing.

The PHN Branch will continue with their immunization clinics for the uninsured and underinsured population.

The CHCs, Healthy Start and WIC programs will continue to provide infant immunization education and referrals as part of its services. The CHCs and Healthy Start providers will continue to collect data on immunization rates.

BIPHDP will continue with their services and promote well child care and immunizations.

HMHB will continue to promote maternal health and provide system building support to improve perinatal services. HMHB will launch a marketing campaign which will include media advertising, resource directory, revitalize website, topic brochures, slogan contest and an E-newsletter.

The Immunization Branch will continue to focus on improving the capacity of the HIR in order to receive data from providers that use electronic medical records (EMR) and establish more provider connectivity to the HIR.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	18.6	18	17.5	17	13
Annual Indicator	19.8	18.7	18.3	12.8	12.0
Numerator	472	432	419	321	297
Denominator	23857	23097	22895	25090	24703
Data Source		Hawaii State Vital records			
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	11	11	11	11	11

Notes - 2011

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.

Notes - 2010

Data is for resident population and is by calendar year. Data for the year 2009 was revised with an updated birth data file. Data for the year 2010 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, 2009" (SC-EST2009-AGESEX_RES). Previous years have been revised based on revised population estimates. Estimates for the 2010 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 2011 to 2015 was changed to reflect a 5 percent improvement from the 2010 annual indicator.

Notes - 2009

Data is for resident population and is by calendar year. Data for the year 2008 was revised with an updated birth data file. Data for the year 2009 is based on a provisional birth data file. Population data based 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, 2008" (SC-EST2007-AGESEX_RES) (May 1, 2009). Estimates for the 2009 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

a. Last Year's Accomplishments

The 2011 data indicate a rate of 12.0 live births per 1,000 teenagers aged 15-17 which met the State objective of 13 per 1,000. The State continues to improve each year. The comparable Healthy People 2020 objective for this Title V measure is to reduce pregnancies among females aged 15-17 years to no more than 36.2 per 1,000 females aged 15-17. Hawaii also meets the HP 2020 objective (21.5 for 2010, latest available data). Of all four counties, Hawaii County teen birth rates are consistently higher than the state average.

The State Adolescent Health Coordinator conferred and collaborated with Title X funded Family Planning Program (FPP), the Hawaii Youth Services Network (HYSN), the Department of

Education's (DOE) health education specialists, and the University of Hawaii's Center on Developmental Disabilities (UHCDD) on various projects to reduce Hawaii's teen pregnancy rates and teen births.

In 2011, HYSN's Teen Pregnancy Prevention (TPP) program experienced problems the selected evidence-based approaches in the setting chosen. Reducing the Risk will be used in the middle schools instead of Draw the Line, Respect the Line, and Making Proud Choices (MPC) will be used in community-based settings. Both curricula will be replicated and evaluated across the State. The program plans to reach 1,890 youth per year, serving primarily Pacific Islander and Filipino youth to increase knowledge about risky sexual activity, delaying of sexual activity, reducing teen pregnancy, and increasing contraceptive usage.

Also in 2011, the UHCDD piloted their TPP Innovation research grant curriculum, Pono Choices. The culturally responsive curriculum was piloted in several intermediate and middle school health classes throughout Hawaii. The locally-developed, culturally appropriate curriculum is an evidence-informed program model developed to specifically meet the culturally diverse needs of Hawaii's middle school target population. The UH will examine several outcomes including those focused on teen pregnancy, STIs, future orientation, and academic achievement. They are implementing a process-level and formative evaluation to help improve the program development, using mechanisms such as focus groups, interviews, feedback, and other data sources.

Title V's MCH Branch received the Administration on Children, Youth and Families (ACYF)/Family and Youth Services Bureau (FYSB) (ACYF/FYSB) State non-competitive grant applications: the Personal Responsibility Education Program (PREP) grant of \$250,000 per year until 2015, and the State Abstinence Education Program (AEP) formula grant of \$122,488 per year until 2014. These grants are available to each state upon application and targets youth at greatest risk of teen pregnancy and geographic areas with high teen birth rates. Forty-five states, Micronesia, Puerto Rico, the Virgin Islands, and the District of Columbia received PREP grants and thirty-seven states and Puerto Rico received AEP grants which are based on the proportion of low-income children in each State or Territory. The AEP sub-awardee, the Boys and Girls Club of Hawaii (BGCH), will provide the match of 43 percent of the project's total cost with non-Federal resources.

The FY 2011 FPP's Contract Health Educators provided 49,125 individual direct contacts at schools, clubs, and other community group presentations. General outreach initiatives included condom distribution to homeless at the beach and through street outreach, health fairs, radio and television broadcasts, Facebook, Twitter, phone book advertisements, newspaper and military guide publication.

To address high rates of teen pregnancy in Hawaii County, the Bay Clinic Community Health Center disseminated three public service announcements (PSAs) to promote parent engagement in reproductive health and communication with their teens. The PSAs also included information to access family planning services provided by Bay Clinic's 5 sites in East Hawaii County. Bay Clinic services are supported by Title X family planning contracts administered by Title V.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide teen pregnancy prevention education to students and communities.	X		X	X
2. Coordinate community planning efforts to prevent teen pregnancy.				X
3. Support inter-agency collaboration and networking to prevent teen pregnancy.				X
4. Provide technical assistance for contracted teen pregnancy				X

prevention programs to promote evidence based interventions and program practice.				
5. Contract for teen pregnancy prevention Outreach Program services and Abstinence Education Programs.			X	X
6. Contract for family planning educational outreach and clinical services.	X	X	X	X
7. Support the administration of the Youth Behavioral Risk Survey in High Schools and Middle Schools to collect student health data for program planning.				X
8. Assure state-funded sex education programs are medically accurate, factual, comprehensive, and age-appropriate information.				X
9. Support research to develop culturally relevant, evidence based teen pregnancy prevention approaches.				X
10.				

b. Current Activities

The 2011 Hawaii Youth Risk Behavior Survey data was released in June. The new Hawaii data shows a decrease from 2009 in public high school students reporting ever having sexual intercourse (44.3% vs. 37.0%), sexual intercourse prior to age 13 (6.0% vs. 5.2%), sexual intercourse with four or more persons during their life (11.1% vs. 8.0%). The 2011 data also indicated 43.9% of high school students who are sexually active did not use a condom during last sexual intercourse compared to 47.7% in 2009. Condom use among Hawaii's adolescents during last sexual intercourse continues to remain below the rest of the nation.

The FPP's health educator works in collaboration with FPP contract providers and the DOE's health education resource teacher to adapt existing evidence-based, reproductive health curricula to be used in the schools.

In September, the first regional Asian and Pacific Islander domestic violence conference will be held on O'ahu. An adolescent track with breakout sessions on bullying, reproductive justice and intimate partner relationships will be a part of this conference.

FPP will also 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 work with Hawaii's diverse families on reproductive health.

c. Plan for the Coming Year

The 2011 provisional data will be revised in next year's report. The annual performance objective for the 2011 to 2015 was changed to reflect a 5 percent improvement from the 2011 annual indicator.

Title V will continue to collaborate with HYSN and the UHCDD to provide training opportunities to the non-profit agencies in positive youth development and teen pregnancy prevention programs by sharing reproductive health training resources from the State Adolescent Health Coordinator's positive youth development and TPP field experts.

The MCHB will be overseeing the implementation, monitoring and evaluation of the teen pregnancy prevention (TPP) program for high school aged youth on Hawaii Island. This project is funded by the federal PREP grant. The goal is to establish 20 Hawaii County teen clubs reaching a minimum of 500 high school aged adolescents with teen clubs in each of the eight school districts across the island, by 2015. Community service learning is a major component of this program. Health educators will assist all teen club facilitators to increase awareness and opportunities to educate adolescents on the use of condoms and contraceptives.

The MCHB will also be overseeing the implementation, monitoring and evaluation of Hawaii's abstinence education grant program on Oahu. The two sites are the Spalding Clubhouse in Honolulu and the NFL Youth Education Team (NYET) in Nanakuli, a rural Oahu community with a large Native Hawaiian population. The goal is to recruit, engage and retain 250 youth participants, 10 to 17 years of age in a positive youth development and abstinence program by 2014. Informal talk story time sessions will be held for all BGCH youth to speak with health educators on sexual and reproductive health.

The FPP's contract health educators will be focusing on the most underserved and least likely youth to access family planning services in a traditional setting. The FPP's contract health educators will provide outreach to low-income, adolescents, and males. Other target groups are the homeless, at-risk youth, immigrants, person with limited English proficiency, population with special needs, clients recently released from incarceration, substance abusers, individuals exposed to or experiencing violence. The FPP's overall goal is to provide outreach services with information on family planning and reproductive health services to promote access to care at the family planning clinic statewide.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	26	26	27	27	28
Annual Indicator	27.7	22.5	22.5	8.9	11.3
Numerator	824	554	554	2609	3461
Denominator	2971	2457	2457	29219	30683
Data Source		Hawaii DOH Dental Health Division	Hawaii DOH Dental Health Division	EPSDT CMS-416	EPSDT CMS-416
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	12	12	12	12	12

Notes - 2011

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.

Notes - 2010

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 Branch 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 is not comparable to prior years as the data for 2010 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".

Notes - 2009

Data is from the Department of Health Dental Health Division (DHD) which conducts the child oral health surveillance program. Oral examinations are conducted by DHD dental hygienists in public elementary schools in accordance with accepted dental epidemiology standards. In November 2009 the DHD Dental Hygiene Branch 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 is used for 2009.

a. Last Year's Accomplishments

The 2011 data indicates 11.3% of eligible children enrolled in the Medicaid EPSDT program ages 6-9 years received a sealant on a permanent molar tooth. This is a new data source for tracking dental sealants. Although the measure does not reflect all children in Hawaii, those in EPSDT are considered at high risk and a key target population to receive dental care. The 2011 data shows a slight improvement over the 2010 indicator.

The DOH Dental Health Division (DHD) previously provided the data for this measure. In August 2009, under the prior Administration, the DHD was eliminated as part of the state workforce reductions. All DHD hygienist services were eliminated including statewide oral screenings at public elementary schools. DOH continues to provide dental treatment services for eligible persons at 4 community-based dental clinics on Oahu and at Hawaii State Hospital. Comprehensive dental care is provided for persons with severe disabilities who are unable to access private sector services.

WIC programs educate their clients on baby bottle tooth decay, early childhood caries prevention and the importance of the dental home and regular care. WIC is currently working with West Hawaii Community Health Center on a co-location model. WHCHC sends a dentist and a hygienist to WIC (which provides space and makes appointments) for kids (0-5). Anticipatory guidance, oral health exams are conducted and fluoride varnish applied. Referrals are made to assure ongoing or follow-up care.

Hawaii's Children with Special Health Needs Branch has worked in partnership with Kapiolani Medical Center to establish the Cleft Lip Clinic.

For the 2nd year Hawaii received an "F" from the PEW Trusts' States report card on children's oral health, meeting only 1 of the 8 policy benchmarks. In response to the failing grade, Title V in conjunction with the Primary Care Association, AAP-Hawaii convened a Children's Oral Health Summit in August 2011. The statewide video conference featured national pediatric dental speakers, policy and service updates, and strategy identification.

The Title V Primary Care Office (PCO) updates federal dental health shortage area designations and provides state dental health subsidies to the community health centers (CHC) for treatment services (subsidies cannot pay for preventive dental services). Of the 14 Federally Qualified Health Centers (FQHC), 12 provide dental services. Services for the uninsured are available on all the major islands through the CHCs or through partnerships with dental providers (see attachment). The FQHCs have increased dental staffing, provided dental training through residency programs, and offered dental hygiene services. Also mobile dental services and outreach efforts were initiated to increase service accessibility.

The Medicaid agency provides dental services through a fee-for-service program that includes care coordination support. MQD increased fees for selected procedures for Neighbor Island providers in accordance with state legislation. In 2007, MQD contracted with Cyrca Dental to administer the dental program. Cyrca was able to decrease required paperwork and authorization requirements, provide outreach and training for providers statewide and case management/referral services through its Community Case Management Corporation (CCMC).

Each Neighbor Island county has an oral health coalition and together they meet as a Tri-County Dental Task Force. Accessing dental services is more challenging on the rural neighbor islands since the highest concentration of dentists remain largely in Oahu. The Hawaii Primary Care Association (HPCA) convenes annual meetings of the State Oral Health Task Force to share information and identify collaborative strategies.

Hawaii Head Start (HS) and Early Head Start (EHS) participated in the national Head Start Dental Home Initiative (DHI) from 2009-2011 to assure early oral health care, access to a dental home, and oral health education. Dental screenings and referrals for follow-up care were provided through CCMC if needed. Preventive education was provided to staff and EHS/HS families.

In 2009 the Lutheran Medical Center's pediatric dental residency program began in Hawaii providing a maximum of 8 residents at any one time. Residents work with children ages 1 to 18 years, primarily those on Medicaid or without dental insurance and rotate through Shriners' Hospital, Hawaii island hospitals, CHCs on Oahu and Hawaii island, and the Aloha Medical Mission.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide funding for dental services to the under- and uninsured through community health centers.		X		
2. Provide oral health education to WIC low income pregnant women and young mothers.		X		
3. Support Neighbor Island oral health community coalitions to plan and conduct activities/programs.				X
4. Convene statewide Oral Island task force to share information, identify strategies and policies to improve oral health for children.			X	
5. Complete dental health shortage designations through the Primary Care Office.			X	
6. Administer state funded subsidies to cover oral health services for the uninsured through community health centers.			X	X
7. Work with key stakeholders to identify and implement specific strategies to improve oral health for children				X
8. Continue Lutheran Medical Center Pediatric Residency program to increase providers for community health centers.				X
9. Work with early childhood practitioners to implement evidence-based oral health curriculum, "Cavity-Free Kids"			X	

training in early childhood programs.				
10.				

b. Current Activities

Services described previously continue. Examples of community level initiatives include the Maui Oral Health Center, a collaborative project which provides affordable dental health care to the underserved. The Hawaii Island Hamakua Community Health Center dental van goes to elementary schools to conduct assessments, fluoride rinses, and referrals to dental services. Kauai continues efforts to develop hospital dentistry.

DOH planning functions for oral health were transferred to the Title V agency. Title V is expected draw upon resources of the Offices of Primary Care and Rural Health to assist. A Division oral health workgroup has been convened that has met initially with Medicaid and its oral health contractors (CCMC) to identify areas for potential partnership including data sharing, policy development, and public education. The workgroup also met with the Primary Care Association and has agreed to partner to convene the State Oral Health Task Force.

As a result of the Oral Health Summit, legislation was introduced to promote children's oral health through education, data collection, and increase Medicaid provider reimbursements; however, the measure did not pass.

The Head Start DHI ended in the 2011 due to changes at the national level. However, HS/EHS staff continues to ensure children receive dental screenings and follow-up treatment through their dental home. Staff continues to provide oral health education to parents.

An attachment is included in this section. IVC_NPM09_Current Activities

c. Plan for the Coming Year

Data will be reported for 2012. The annual objectives were changed to reflect a 5% improvement from the 2011 indicator.

The Kona WIC co-location of oral health services project was initiated in conjunction with the West Hawaii Community Health Center and the Hawaii Island Oral Health Coalition, with TA from the HRSA Region 9 Office. WIC will evaluate the model of co-location of services for replication with other CHC partners. There are plans to expand the project to Hilo and Maui WIC offices in 2012-2013.

Although funding from the DHI will no longer be available as of July 2012, EHS/HS programs will continue to address the oral health needs of their children. Partnerships with key community entities, including the Lutheran Medical Center residency program and the oral health task forces on the neighbor islands, will help leverage resources to support this effort.

Neighbor island oral health coalitions will continue to work with CCMC to track and minimize off-island services through the expansion of local services and education/outreach efforts.

Title V will work on developing oral health planning capacity and work with PCA to convene the State Oral Health Task Force in September. Collaboration will continue with the dental providers, pediatricians, and community programs serving families to ensure that each child has a dental home and is accessing routine care, particularly those deemed high risk, Medicaid eligible children and children with special health care needs. Title V will also ensure oral health is integrated into all appropriate direct service programs/contracts. Effort will also be made to coordinate with obesity prevention projects to develop information on the detrimental effects of sugar sweetened beverages on oral health.

Title V PCO will continue to process the oral health underserved federal designations and continue its state funded grant subsidies to various community health centers in all four counties.

Strategies from the Children's Oral Health conference for follow-up include expansion of fluoride varnish applications by non-dental providers to at-risk young children; development and expansion of hospital dentistry for CSHN (and DD adults); increase oral health education efforts; establish a data collection system; and expand service delivery methods (co-location of services, virtual dental offices).

Title V will partner with the Medicaid agency to explore the availability of provider data to help the PCO secure more Health Professional Shortage Designations (HPSD) for the state. Shortage designation criteria consider whether providers are serving Medicaid or uninsured populations; however, accurate data is challenging to secure since provider survey response rates can be poor and information is self-reported. Data from Medicaid on provider dental claims can help with HSPD applications and improve HSPD scores to increase the likelihood of getting National Health Service Corps dental placements of in these high need areas.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	1.4	2	2	2	1.5
Annual Indicator	2.5	2.5	2.2	1.6	1.6
Numerator	18	18	16	12	12
Denominator	712175	712175	723970	736378	749565
Data Source		Hawaii State Vital records			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	1.5	1.5	1.5	1.5	1.5

Notes - 2011

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).

Notes - 2010

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 2009 was revised with an updated death data file, while data for the year 2010 represents deaths from the updated 2008 and 2009 death files and the provisional 2010 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, 2009" (SC-EST2009-AGESEX_RES). Estimates for the 2010 population were not available from the Census Bureau at time of this report so population data from 2009 was carried to 2010.

Notes - 2009

Due to the small number of motor vehicle deaths, a three-year annual average is being reported. The reported data maybe too small to calculate reliable measures. Unstable measures are not useful in making decisions. Caution should be exercised in the analysis of the reported data. Data is for resident population and is by calendar year. Data for the year 2008 was revised with an updated death data file. Data for the year 2009 is provisional. Population data based 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, 2008" (SC-EST2007-AGESEX_RES) (May 1, 2009). Estimates for the 2009 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.

a. Last Year's Accomplishments

The provisional data is 1.6. The state objective was not met; however, rates have stayed relatively stable. Motor vehicle (MV) related injuries continue to be the leading cause of injury death for Hawaii children aged 10-14 years during 2004-2008. Title V collaborates with The Keiki Injury Prevention Coalition (KIPC), DOH Injury Prevention program, and the State Department of Transportation (DOT) to provide information on modifiable risk and promote education through an extensive network of community agencies.

The DOT continued to support child passenger safety through enforcement strategies and education. All 4 county police departments received DOT funding to enforce state Child Passenger Restraint laws. A highlight of this effort was checking for compliance at public schools statewide. The Hawaii Department of Education permitted the county police departments to have officers check for compliance during drop-off/pick-up periods throughout the year. All parents and caregivers received information about Hawaii's child restraint law prior to this enforcement.

The police departments also set up roadblocks to check for child safety seat violations and assisted with child restraint seat inspections and installations at community car seat checks. During this year, police issued 2,206 child safety seat citations.

Non-profit organizations Keiki Injury Prevention Coalition (Oahu) and the Hawaii Alliance for Youth (Hawaii County), along with the Kauai Police Department and Maui Police Department, were issued DOT grants to oversee and implement child passenger safety efforts, such as maintaining fitting stations, conducting training and coordinating community car seat checks. Queens Medical Center sponsored an inaugural Safe Keiki Baby Shower for pregnant teenagers and young parents. Participants received a free convertible or infant car seat. Throughout the year, these traffic safety partners conducted safety activities resulting in the inspection of 874 child passenger seats at 41 sites around the state and certification of 64 new child passenger

safety technicians.

Hawaii Safe Routes to School (SRTS) Network, a statewide partnership dedicated to removing barriers to walking and bicycling to and from school, continued to sponsor Walk & Bike to School Day as well as a Statewide Summit that gathered leaders from transportation, health, housing and policy together. The City and County of Honolulu funded the Hawaii Bicycling League's program, BikeEd for reaching 8,000 4th grade students.

Peoples Advocacy for Trails Hawaii (PATH), on Hawaii Island, conducts BikeEd program to 4th grade students in Hawaii County as well as PedEd classes , pedestrian safety education to 1st, 2nd and 3rd graders. PATH also continued their successful SRTS initiative with 4 schools reaching over 2,500 students.

The Queens Medical Center and Farmer's Insurance sponsored live television safety segments on choosing the appropriate booster seat and bike helmet and addressed the new AAP guideline of rear facing safety seat up to age 2.

The DOH Emergency Medical Services and Injury Prevention Branch established a statewide trauma system and registry including an EMS electronic data system to support tertiary injury prevention. The Hawaii Injury Prevention Plan (HIPP) 2011-2015 offer strategies for motorcycle and moped safety, impaired driving, and occupant protection and pedestrian and bicycle safety. Hawaii has been progressive in passing traffic safety legislation. Legislative priorities include Ignition Interlock Bill revision and Vehicle Immobilization for DUI Offenders, Complete Street design laws for the state and counties, Vulnerable Road Users Bill, and Universal Helmet Law for moped, motorcycle, bicycle and All Terrain Vehicle (ATV) riders.

The Hawaii Home Visiting Network, supported by the Title V federal Home Visiting grant, promotes measures on street and car safety in the program assessments and appropriate prevention education targeted to developmental stages.

The Hawaii Child Death Review (CDR) system, administered by Title V, continues to update participants on policies. The National Highway Traffic Safety Administration released a proposal that would require all new cars starting in 2014 to have rearview cameras and interior displays to allow "a 180-degree view" of the area around a car to prevent "Blind Zone" deaths. Hawaii had the 4th highest number of "Blind Zone" deaths in the U.S. The peak age for these deaths is 1 year of age.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect data/information on child injury and death to use for policy development and planning.				X
2. Conduct educational outreach on child passenger seats, bicycle and pedestrian safety.	X	X	X	X
3. Enforce seat belt and child safety restraint laws through program and training police department staff.				X
4. Conduct safety seat checks through an extensive network of permanent sites and at special events.		X	X	X
5. Identify prevention strategies by reviewing plans and surveillance information surrounding child deaths.				X
6. Support state and community injury prevention coalitions.				X
7. Implement provisions of the Hawaii Strategic Highway Safety Plan 2013-2017 and the HIPP 2011-2015 through advocacy for roadway safety policies, enforcement and community based				X

programs.				
8. Promote safe/active school transportation models through Safe Routes to School.				X
9.				
10.				

b. Current Activities

Major legislation was adopted this year to promote MV/roadway safety. The Oahu Complete Streets Ordinance requires policies to accommodate all users of the road, regardless of age, ability, or mode of transportation and a state bill was passed to formally establish the SRTS program within the DOT. A surcharge for traffic violations will be deposited to the SRTS Special Fund effective July 2012. Other state legislation addressed mandatory minimum sentencing for negligent homicide or injury involving the operation of a MV when a vulnerable highway user is involved; requesting DOH to convene a Task Force to examine ATV accidents on children; allocation of Trauma System Special Funds for Injury Prevention positions, a core component of the comprehensive trauma system.

WIC is partnering with Kaiser Permanente's Child Passenger Safety Program, on Hawaii Island (which has a high rate of traffic fatalities), to conduct car seat fittings for WIC participants in the clinic parking lot and provide older toddlers with free bike helmets.

Continued statewide enforcement campaigns (such as the annual "Click It or Ticket" program) increase use of seat belts and child restraints. DOT grants support continued regular Child Safety Seat Checkups.

Motor vehicle and child passenger safety plans will be available in the revised HIPP. The Child Death Review Program released findings from the review of 2001-2006 child deaths. The DOT hired a full time SRTS coordinator.

c. Plan for the Coming Year

The numbers for this measure remain small. Objectives for this measure have been set at the rate of 2 deaths per 100,000 children.

WIC will continue to partner with Kaiser Permanente's Child Passenger Safety Program, on Hawaii Island (which has a high rate of traffic fatalities), to conduct car seat fittings for WIC participants in the clinic parking lot and provide older toddlers with free bike helmets. The program rotates WIC clinic sites every month and have been popular with clients.

Partners will support implementation of the Hawaii Strategic Highway Safety Plan 2013-2017 and the HIPP 2011-2015. Other planning efforts to address impaired drivers, distracted drivers, "Blind Zones, and helmet usage are in underway. Mothers Against Drunk Drivers (MADD) and The Queens Medical Center are working closely with the DOT, prosecutors, county police forces and IPCP to assure procedures are in place statewide for timely testing of impaired drivers (within 3 hours of the event). Advocates will re-introduce helmet bills that will require support in the next legislative session.

Community members, with IPCP and the Queens Medical Center, are working with two national advocacy groups, KIDS and CARS and End Distracted Driving, to develop strategies to address distracted drivers, "Blind Zones, and helmet usage.

Police departments lead county efforts to promote roadway safety education in addition to child passenger safety enforcement. Examples of educational programs include; Junior Police Officer (JPO) for the prevention of motor vehicle and pedestrian collisions by developing awareness, knowledge and skill in pedestrian safety among children, the GET SAFE - Giving Every Teenage Student an Alcohol Free Education, presentations directed at teenaged students, focusing on

underage drinking, speeding, and making good choices.

The Hawaii Home Visiting Network program will continue to provide traffic safety information to enrolled families to assure child safety during play and in cars to increase use of child safety seats, seat belts, helmets, and supervision of play near cars and safe walking. This program will also track the number of visits for children to the emergency room. The Child Death Review program will invite existing prevention groups to share information about current policies and resources and in turn share data and recommendations to support stronger policies and prevention campaigns.

The SRTS Coordinator will release a Call for Applications for proposed infrastructure and non-infrastructure SRTS projects to be considered to receive federal SRTS funds. In addition, the DOT plans to offer one SRTS workshop on the islands of Kauai, Oahu, Maui and Hawaii. These workshops will be designed to bring together stakeholders and provide them with information about the strategies and techniques for SRTS implementation. SRTS will continue to build partnerships to promote walking and bicycling to school among students K-12.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	47	48	55	56	64
Annual Indicator	55.2	56.7	56.2	60.4	52.4
Numerator					
Denominator					
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	64	64	64	64	64

Notes - 2011

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.

Notes - 2010

The data for this measure is from the 2009 National Immunization Survey (NIS), Centers for Disease Control (CDC) Department of Health and Human Services. Data is reported by the year of the child's birth to make it easier to evaluate breastfeeding interventions and progress toward the Healthy People 2010 breastfeeding objectives, based on a sample of 226 children with completed household interviews. The latest data is from birth year 2006. This data is used to report for FY 2009. Data for the 2006 cohort is provisional, to be updated in 2011. Data for the 2005 cohort is updated.

The annual performance objective for the years 2011 to 2015 was changed to reflect a 5 percent improvement from the 2010 annual indicator.

Notes - 2009

The data for this measure is from the 2009 National Immunization Survey (NIS), Centers for Disease Control (CDC) Department of Health and Human Services. Data is reported by the year of the child's birth to make it easier to evaluate breastfeeding interventions and progress toward the Healthy People 2010 breastfeeding objectives. The latest data is from birth year 2006. This data is used to report for FY 2009. Data for the 2006 cohort is provisional, to be updated in 2011. Data for the 2005 cohort is updated.

a. Last Year's Accomplishments

The provisional FY2011 data indicates that in 2008, 52.4% of Hawai'i mothers were breastfeeding their infants at 6 months, the lowest percentage since birth years 2003-2006. The 2011 indicator did not meet the objective of at least 60.5% of women breastfeeding their infants at 6 months of age, however Hawaii surpassed the national rate of 44.3%.

The Title V program promoted breastfeeding by providing enabling, population based, and infrastructure building services. Title V perinatal support services contractors provide comprehensive breastfeeding education and support to clients. Other community-based programs that promoted breastfeeding include: the federal Healthy Start Project on the island of Hawaii; Early Head Start, and programs under the Native Hawaiian Health Systems.

DOH HHI was awarded CDC funding for the Baby Friendly Hawaii project. A consultant was hired to provide technical assistance. Close to 30 staff from 11 maternity care hospitals participated in a Train the Trainer session in August 2011. HHI has also provided materials for the trainers to teach the 20 hour breastfeeding course in their respective hospitals. The Baby Friendly Hawaii Project consultant made four visits to Hawaii. On those visits, she provided several staff trainings, community presentations, met with hospital staff and administrators, conducted mock Baby Friendly visits, and provided individual hospital meetings/technical assistance. Five hospitals have either registered with Baby Friendly USA or are in the process of registering towards designation. The project was awarded a no-cost extension through the end of February 2013. HHI also collaborated with the Kauai DHO to organize a breastfeeding symposium. The symposium featured presentations regarding breastfeeding in the workplace.

WIC promoted the August 2011 World Breastfeeding theme "Talk to Me! Breastfeeding a 3D Experience" by sharing ideas with staff on how to begin the conversation with those who serve as a support system to the breastfeeding or pregnant mother. WIC continues to promote a nationally recognized Pumps in the School (PITS) Program in 3 high schools statewide (eleven less than the three years before due to education program closures), and breastfeeding peer counselors (BFPC). WIC maintained state and local agency level breastfeeding coordinators (BFC) and hosted the Centers for Disease Control (CDC)/United States Breastfeeding Coalition (USBC) bimonthly teleconference for the State of Hawaii. WIC's State Conference on September 26 and 27, 2011 focused on breastfeeding. 154 WIC staff attended day 1 of the conference while 74

CPAs attended day 2 of the conference.

WIC contributed breastfeeding data to the national Pediatric Nutrition Surveillance System (PedNSS) report, which represents low income residents in Hawaii. The 2010 Hawaii rate measuring any breastfeeding at 6 months was 40.8% which continues the increasing trend since 2008 (38.1%) but a slight decrease over 2009 (41.3%) and was better than the 2011 national rate of 25.1%. Because WIC serves low-income, high-risk women the rates for breastfeeding are expected to be lower than for the general population.

WIC contracted with Family Support Services of West Hawaii (FSSWH) to provide BFPC training to their home visiting staff as well as staff from the Kona WIC Program and community partners like Alu Like (a service agency for Native Hawaiians) and Kona Community Hospital. BFPC can provide breastfeeding information to prenatal and postpartum WIC clients via clinic, home, and hospital visits. WIC received increased BFPC funds.

Breastfeeding Hawaii, the state breastfeeding coalition, is currently focused on making strides in lactation accommodation in the workplace. They were actively involved in advocating State I SB2573/HB2228 which would require employers with more than 20 employees to be responsible for providing appropriate lactation accommodations for their employees. This law takes the federal law requiring employers with more 50 employees a step further in requiring smaller businesses to also comply. In addition to the accommodations, employers would also need to post a notice in their workplace regarding this law or face a civil fine.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract to provide breastfeeding education and support to high-risk pregnant women statewide.		X	X	
2. Provide breastfeeding promotion, education and support to WIC pregnant and postpartum clients.	X	X	X	X
3. Support, encourage and advise hospitals in moving towards changing organization policies and practices to qualify for "Baby Friendly Designation".				X
4. Provide information on breastfeeding to the public and professionals.			X	X
5. Support networking among programs and advocating for policies that support breastfeeding				X
6. Collect breastfeeding data.				X
7. Plan statewide breastfeeding promotional events and campaigns.				X
8. Conduct training and certification for breastfeeding counselors and lactation consultants.				X
9. Procure services to provide breastfeeding peer support according to the "Loving Support" curriculum and guidance.		X	X	X
10.				

b. Current Activities

DOH HHI's CDC funding for the Baby Friendly Hawaii project has been given a no cost extension until February 2013. The consultant provided technical assistance in April 2012 by offering a trainer workshop to statewide trainers, performing mock Baby Friendly designation visits to 3 hospitals, 2 days of staff training at 1 hospital, a community group meeting and smaller hospital work-group meetings.

WIC will promote the World Breastfeeding Event in August 2012 "Understanding the Past,

Planning the Future". WIC is also taking part in a Department-wide collaboration to record an episode for a public access program that will feature the Department's breastfeeding related activities.

WIC has established and hired 2 State Agency Peer Counseling (PC) Program positions (PC Project Coordinator and Peer Counselor) and anticipate their start date to be in July 2012. A second Peer Counselor position is in the process of being established. PC funds have also been awarded to 2 local agencies (Kokua Kalihi Valley Health Center and FSSWH).

FSSWH and the West Hawaii Perinatal Consortium continue a project with Kona Community Hospital to promote exclusive breastfeeding. In place of free baby bags with formula, mothers are given a breastfeeding pillow, a breastfeeding instructional DVD, tips for dads on how to support breastfeeding, and contacts for lactation support. FSSWH home visiting programs provide targeted infant feeding education and support prenatally to mothers.

c. Plan for the Coming Year

Final data for births in 2008 (2011 reported data) will be provided in next year's report from the NIS. Objectives for this performance measure were set to 61% which is the HP2020 goal for 6 months breastfeeding duration.

Hawaii has a history of strong breastfeeding initiation rates. Breastfeeding duration rates may be undermined by certain factors such as introduction of formula before the mother's milk has come in. The 2011 Breastfeeding Report Card from the CDC indicates that 24% of infants born in Hawaii are given formula before they are 2 days old.

DOH HHI will continue activities for the Baby Friendly Hawaii project. HHI will be: conducting monthly trainer conference calls; procuring training materials for hospitals/trainers and paying for Baby Friendly USA registration fees.

WIC will continue to support the efforts of the State breastfeeding coalition to assure employees are provided adequate pumping breaks and assure that breastfeeding women are protected from discrimination. WIC will continue to encourage the establishment of lactation rooms at each DOH building.

The Title V programs will continue to provide breastfeeding education and support to high-risk pregnant women. DOH will explore external funding opportunities that would secure a breastfeeding professional position across all programs in the near future.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	98	98	98.4	98.4	98.4
Annual Indicator	98.1	98.9	97.5	98.1	98.7
Numerator	18725	19170	18389	18564	18620
Denominator	19085	19377	18858	18914	18869
Data Source		Hawaii NHSP	Hawaii NHSP	Hawaii NHSP	Hawaii NHSP
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	98.4	98.4	98.4	98.4	98.4

Notes - 2011

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

Notes - 2010

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) are preliminary.

Notes - 2009

For 2003-2005, the denominator is from vital records of live births minus deaths before 24 hours. 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 Early Hearing Detection and Intervention (EHDI) program. Data is reported by calendar year to the Centers for Disease Control and Prevention. Data for CY 2008 was updated. Data for 2009 is preliminary.

a. Last Year's Accomplishments

The 2011 preliminary data show that 98.7% newborns were screened for hearing before hospital discharge. The CY2011 Title V objective was met and the HP 2020 objective of 90.2% screened by 1 month was exceeded. The 2010 indicator was updated to 98.2%, which was below the objective of 98.4% but showed improvement from CY2010.

Newborn Hearing Screening Program (NHSP) began in 1990 through a law mandating that the DOH develop methodology to establish a statewide program for screening of infants and children age 0-3 years for hearing loss. Screening began in 2 hospitals in 1992, was provided in all birthing facilities by 1999, and is now part of standard newborn care in Hawaii.

The NHSP law was amended in 2001 to mandate screening of all newborns for hearing loss and reporting screening results to the DOH. In 2003, NHSP began outreach to homebirth families statewide through midwives. Hearing screening is now available to families statewide, regardless of birth location. By November 2006, all hospitals have both otoacoustic emissions (OAE) and automated auditory brainstem response (AABR) screening capability and have backup equipment.

All 12 of the birthing hospitals screen babies. Eleven of twelve hospitals transfer child-specific data to the state NHSP HI*TRACK data system. The remaining hospital submits annual aggregate data to NHSP. Because that data is not adequate for state follow-up purposes, discussion continues with that hospital regarding child-specific data submission.

NHSP continued to work closely with hospitals and medical home providers in 2011. NHSP worked with hospitals monthly to reconcile state data against hospital delivery logs and track

follow-up needs. The NHSP HI*TRACK data system at the central office was converted to web-based in May 2011. As of September 2011, four hospitals had also converted to web-based. The real time data with immediate access facilitated timely services and better follow-up.

NHSP supported staff development and sponsored two trainings last year. The "Engaging Parents to Improve Outcomes for Children" was a statewide conference aimed to strengthen skills of providers who worked with families of children who were deaf or who had special needs. The newborn hearing screening training was targeted for screeners who administered the screening at the hospitals. The training emphasized implementing the two stage, OAE/AABR screening.

The Hospital Newborn Hearing Screening Coordinators Committee met in June 2011. At the meeting, accomplishments and challenges were shared among coordinators, suggestions for program improvement were solicited, and new or revised policies were discussed. NHSP implemented two new policies as a result of activities that were piloted in 2010. Parents of babies who received screening were provided written documentation of the screening results as well as the "Good Hearing Helps a Baby Learn to Talk" brochure. Parents of babies who did not pass screening received in addition the "Family Guide", a roadmap to guide parents through the screening, evaluation and early intervention process. All screening and evaluation results were sent to the child's medical home.

The sole audiologist on the island of Kauai stopped servicing children under two years old in 2009. Last year, NHSP established an agreement with an audiologist from Oahu to provide services on Kauai once a month. Screening/diagnostic equipment was loaned to the audiologist. In return, she provided services to babies who needed screening follow-up or who missed screening. This arrangement minimized the number of babies needing to travel to Honolulu for follow-up services.

NHSP and the Newborn Metabolic Screening Program (NBMS) coordinate 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.

An initial draft of the Administrative rules for NHSP was completed. The NHSP coordinator attended training on Writing of Administrative Rule.

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct newborn hearing screening at all birthing hospitals in Hawaii.	X	X	X	X
2. Assist with follow-up for rescreening, audiological assessment, or risk for late onset hearing loss.	X		X	X
3. Monitor hospital newborn hearing screening rates and assist in addressing screening barriers.				X
4. Homebirth newborn hearing screening outreach and monitor impact on screening rates.		X		X
5. Software/technical assistance to birthing hospitals to facilitate reporting of screening results.				X

6. Develop database linkages to identify infants who may not have received hearing screening.				X
7. Develop/disseminate public awareness materials on early hearing detection and intervention (EHDI).				X
8. Education/training for hospital screening staff, parents, audiologists, and other providers about EHDI.		X		X
9. Establish administrative rules for EHDI that are consistent with state newborn hearing screening law.				X
10.				

b. Current Activities

Hearing screening continues in all birthing facilities. NHSP assists with follow-up, monitors hospital screening rates, and provides technical assistance. HI*TRACK software is provided at no cost to hospitals. By December 31, 2011, all hospitals which submitted screening data to NHSP using the HI*TRACK data system were converted to web-based. NHSP staff and HI*TRACK consultants provide ongoing technical support to ensure smooth transitioning to a web-based system.

NHSP sponsored two trainings in the current year. The "Screening Conference" was offered to Early Childhood providers statewide in February 2012. The "Shining the Light on Young Deaf, Hard-of-Hearing and Deaf-Blind Children" Conference in March 2012 was cosponsored by the Hawaii Deaf and Blind Project and the Gallaudet University Regional Center and was attended by early interventionists and parents.

NHSP and NBMSp staff met with a group of midwives on Kauai to discuss a possible contract to provide screening to homebirths. NHSP collaborates with the American Academy of Pediatrician (AAP)-Hawaii Chapter Hearing Champion to provide training to pediatricians on the neighbor islands.

NHSP purchased hearing screening equipment (7 units)--three to replace older equipment at hospitals and four to be loaned to community providers who agree to screen homebirths.

NHSP staff visited four birthing hospitals to provide one on one support on the web-based HI*TRACK data system and to ensure implementation of the two stages screening.

c. Plan for the Coming Year

Newborn hearing screening will continue in all birthing facilities. NHSP staff will continue visits to all birthing hospitals to provide one-on-one support in the screening protocols and in the database system.

NHSP will strengthen collaboration with community providers to assist with follow-up for infants who need rescreening or referrals for audiological assessments and intervention, as well as for infants being monitored for late onset of hearing loss. Meetings with the Early Head Start programs and the Home Visiting programs will be scheduled to discuss possible collaboration.

Data collection and tracking procedures will be improved. The program will continue linkages with newborn metabolic screening and early intervention databases to help locate children who are otherwise lost to follow-up/documentation. Efforts to involve primary care providers and Part C early intervention providers in the follow-up process will be expanded.

Newborn hearing screening/follow-up rates will continue to be monitored. Strategies will be implemented to help hospitals further address screening barriers and decrease loss to follow-up/documentation at the screening stage of the early hearing detection and intervention (EHDI) process. NHSP will continue contacting hospitals monthly to reconcile state data against hospital delivery logs. NHSP and the NBMSp will continue joint quality assurance activities. Meetings with

midwives on all neighbor islands will be scheduled to assist in improving screening rate for homebirths.

Educational sessions/training will continue to be provided for hospital newborn hearing screening staff, audiologists, physicians, early interventionists and other providers. The AAP Hearing Champion will continue training to pediatricians on the neighbor islands. The Hawaii Practitioner's Manual for Early Hearing Detection and Intervention will be revised with updated information.

NHSP will work together with the newly hired Deaf Educator to provide parent support to families with children with hearing loss at the diagnostic and intervention stages of the EHDI process and will continue to facilitate statewide family support activities. The contracted NHSP Audiologist continues to assist with quality assurance and provide audiological consultation. Loaner equipment and lending library materials will be disseminated as needed.

The EHDI Advisory Committee and the Hospital Newborn Hearing Screening Coordinators Committee will continue to meet and provide input on state program policies and procedures. Parents are encouraged to be active members of the Advisory Committee and other parent support group activities.

The initial draft of the administrative rules will be further revised and NHSP will continue the lengthy process to establish administrative rules.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	1.8	1.4	3.7	3.7	2
Annual Indicator	3.9	2.4	2.3	2.3	2.3
Numerator	11545	6815	6645	6645	6645
Denominator	293374	286312	289496	289496	289496
Data Source		Hawaii Health Survey	Hawaii Health Survey	Hawaii Health Survey	Hawaii Health Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	2	2	2	2	2

Notes - 2011

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.

Notes - 2010

The data is from the Hawaii Health Survey administered by the Department of Health, Office of Health Status Monitoring. It is a continuous statewide household survey of health and socio-demographic conditions.

The annual performance objective for the years 2011 to 2015 was changed to reflect a 5 percent improvement from the 2010 annual indicator.

Notes - 2009

The data is from the Hawaii Health Survey administered by the Department of Health, Office of Health Status Monitoring. It is a continuous statewide household survey of health and socio-demographic conditions. The HHS started in 1968. In 1996, the survey converted to a telephone survey that focused on respondents 18 years of age and older that was knowledgeable about their household in order to collect information on persons of all ages living in the household. In 2004, 6,789 household respondents were interviewed and information on a total of 19,669 household members was obtained. This information is then weighted to reflect statewide estimates excluding households without telephones, Niihau, those living in group quarters, and those that are homeless. The survey provides demographic information for observing population changes during the intercensal decade. It provides state and sub-area estimates of gender, age, income, race, education, household size, insurance status, health status, morbidity, and food security.

a. Last Year's Accomplishments

In FY 2011, an estimated 2.3% of Hawaii's children 0 to 17 years were without health insurance. While the statewide measure was not met, the overall percent of children statewide with health insurance remained quite high at approximately 97% representing over 273,000 children with insurance.

The health of children depends at least partially on their access to health services. The lack of health care insurance can be an important barrier to accessing care. There are a number of major efforts promoting access to healthcare insurance for Hawaii's children.

Title V programs working with families with children continue to provide assistance and referrals to help secure insurance coverage for children including WIC, Children with Special Health Needs, Perinatal Support Services, and the federal Home Visiting program.

The Hawaii Quest (Medicaid) policy for children accepts household gross income up to 300% FPL (\$6,630 month for a family of four). Household assets are not counted. There is no cost for physician office visits, well-child care, and routine physical examinations (school). Similarly, immunizations are covered as is prescription drugs, and ED visits. Dental diagnostic and preventive services are also covered. With the poor economy, the Quest and CHIP programs have seen increases in the number of children enrolled over the years. From June 2009 through May 2011, over 4,350 additional children were enrolled in Quest/CHIP.

The safety net in Hawaii includes 14 Federally Qualified Health Centers (FQHC) and their satellite sites. In 2011, the FQHCs provided care to 128,000 patients of which 48% were enrolled in Medicaid and 25% were uninsured. FQHCs also assist eligible clients enroll into Medicaid or seek other insurance coverage options. The Primary Care Office (PCO), under Title V, contracts the 14 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 but are not limited to perinatal, pediatric, and dental treatment.

Hawaii Covering Kids (HCK) has been the major leader addressing the problem of uninsured children since 1999. HCK is currently contracted by the DHS Med-Quest Division (MQD), to identify, enroll and retain eligible children in health insurance programs, and to improve policies and procedures that increase enrollment of children, in health insurance. HCK collaborates with

federal, state and community agencies to conduct outreach activities, and has been extremely successful in leading and initiating efforts to increase children's enrollment into Medicaid and private insurance over the past 12 years through streamlining eligibility procedures, developing media/public education, conducting outreach, providing training, evaluation and policy analysis. Using the resources provided through the 2009 the Children's Health Insurance Program Reauthorization Act (CHIPRA).

HCK activities in 2011 included a "Back-to-School Campaign", a postcard initiative mailed to over 67,000 households with children ages 0-18. HCK supported several media efforts including newspaper advertisements in 15 community newspapers on six islands. To find and enroll eligible teens, a rural radio initiative was launched on 31 AM and FM stations. Additional media efforts included a 30-second movie advertisement featured at 187 theaters on three islands. The same advertisement ran on television cable and island channels. Poster displays were held at 15 shopping malls on four islands as well as a bus poster event. To increase awareness about the number of newborns born without health insurance, a mailing initiative was repeated with 90,000 postcards sent out to households with women of reproductive age.

Funded by the MQD, HCK sponsored a training event for outreach and eligibility workers from across the state. Each participant was required to develop their own implementation steps for an outreach activity in their community to create awareness about children's health insurance. Training was also provided on completing MQD's application forms and how to respond to eligibility questions.

HCK continued to reach families through multiple agencies and programs as legal aid offices, unemployment office, youth clubs, child care centers, schools, community health centers, hospitals, WIC, Head Start, and Native Hawaiian organizations.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop and implement new strategies for outreach to enroll uninsured children				X
2. Develop and implement, in collaboration with the state Medicaid agency new strategies to simplify the application and enrollment for the program.				X
3. Require Title V contractors to refer eligible uninsured children for insurance coverage.				X
4. Provide updated and timely user-friendly information and application materials to families regarding Medicaid program changes.			X	X
5. Ensure collaboration between the state Medicaid agency, state health insurance plans, policymakers, and community service agencies to assure coverage for uninsured children.				X
6. Support the leadership efforts of Hawaii Covering Kids to coordinate and assure statewide efforts continue to identify, enroll and retain children in health insurance plans.				X
7. Monitor Hawaii health insurance plans to assure mandates of the federal Health Care Reform are implemented so families with children are offered greater options for coverage.				X
8.				
9.				
10.				

b. Current Activities

Program activities continue as described previously. HCK continues to support and facilitate the enrollment of children and youth without health insurance. The Primary Care Office (PCO) continues to contract with the 14 FQHCs as well as three private clinics to provide comprehensive primary care services to uninsured and underinsured using state subsidies.

Title V programs working with families of children continue to provide assistance and referrals to help secure insurance coverage for children including WIC, Children with Special Health Needs, Perinatal Support Services, and the federal Home Visiting program.

The passage of the Patient Protection and Affordable Care Act brings new potential to expand health coverage for all children. Hawaii health insurers may no longer offer policies for children with exclusions for pre-existing conditions.

The 2010 Hawaii Health Survey found children 0 to 14 years were covered predominantly through private insurance (57.7%) and Quest, Hawaii's Medicaid plan (19.8%). A much smaller percent were covered under the military plan (3.7%) and through Medicaid, Medicare, or an unnamed plan (2%). Over 17% of respondents indicated they were insured but did not know the plan name, or the insurance status was unknown, they were uninsured, or the respondent refused to answer.

c. Plan for the Coming Year

Title V will work with DOH Hawaii Health Survey staff to update data for this measure. Hawaii's success with CHIP enrollment may make it challenging to continue increasing enrollment using traditional outreach and marketing activities. An article published in the October 2010 Health Affairs journal noted, "...it is not clear how much higher participation can be in the states that already have rates greater than 90 percent, given the dynamic nature of family circumstances and eligibility for public coverage." But, Hawaii's healthcare community will continue to work towards 100% coverage and access to services.

Program activities continue as described previously. The Primary Care Office (PCO) continues to contract with the 14 FQHCs as well as three private clinics to provide comprehensive primary care services to uninsured and underinsured using state subsidies.

Title V programs working with families of children continue to provide assistance and referrals to help secure insurance coverage for children including WIC, Children with Special Health Needs, Perinatal Support Services, and the federal Home Visiting program.

HCK continues to support and facilitate the enrollment of children and youth without health insurance. At this time, funding for the organization is uncertain with only minimal funding for staff and minor outreach activities. Med-QUEST no longer contributes money for children's health insurance outreach, a major funder for HCK. Legislation that would have funded HCK did not pass. Hawaii Community Foundation continues to provide some private funds for the program to continue. Title V will monitor the impact of this situation.

One of the major new initiatives HCK organized is the Newborn Workgroup. Approximately 300-350 newborns each month must be added to their mothers' Med-QUEST case. Med-Quest does not allow health insurance companies to accept medical claims for newborns using the mothers' Medicaid identification numbers. Thus, effort must be made to assure newborns have his/her own number case numbers. Many of the babies born to Med-QUEST mothers are also not connected to pediatricians, and are going to hospital emergency departments for health care services and regular newborn visits. The goal of the Newborn Workgroup is to assure babies born to mother currently enrolled in Med-QUEST will receive timely and appropriate health care.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	22	21	20	19	18
Annual Indicator	21.5	21.4	22.1	21.6	21.5
Numerator	3215	3447	3812	3851	3844
Denominator	14952	16106	17252	17827	17879
Data Source		PedNSS	PedNSS	PedNSS	PedNSS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	19	19	19	19	19

Notes - 2011

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.

Notes - 2010

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).

Notes - 2009

Data is from the Centers for Disease Control (CDC) Pediatric Nutrition Surveillance System (PedNSS). Data for 2006 is not available due to data quality issues. The problems have been addressed by the WIC program and data has been resubmitted to CDC.

a. Last Year's Accomplishments

The data for 2011 indicates 21.5% of WIC children ages 2-5 years were overweight or obese. The state objective was not met. The rate of overweight/obese among WIC children has remained relatively stable over the past 5 years. However, the estimate in Hawai'i remains significantly lower than the national average of 30.5% (prior year) for states reporting PedNSS data. Also, WIC children ages 2-5 years who were reported as obese in 2011 is 9.2% which is lower than the HP 2020 Objective of 9.6%.

The Hawaii WIC program assists pregnant women, new mothers and young children to eat well

and stay healthy by offering interventions during times of rapid growth and development. Core services include routine health screening and nutrition assessment of all infants and children on the WIC program. The new WIC food packages were implemented October 2009 and included reduced fat milk, fruit/vegetables, whole grains, baby foods and soy alternatives to support healthier food choices. WIC materials were developed to educate parents and caregivers on encouraging physical activity and provide suggestions that are developmentally appropriate for children ages 1-5.

To promote healthy weight for children, WIC developed a curriculum that focuses on 3 behaviors: physical activity, grocery shopping, and anytime vs. sometime foods. The curriculum uses motivational interviewing and stages of change to customize the discussion. As a supplement to the encounter, families were offered a kit which includes a family guide and DVD that shows Sesame Street characters modeling healthy behaviors. Also, WIC purchased a children's book "Move 'Um" developed by the Honolulu Community Action Program Head Start Program.

WIC partnered with the Head Start State Collaboration Office by inviting staff to training on infant and child feeding practices related to childhood obesity in September 2011.

Child obesity was again selected as a state priority through the Title V 2010 needs assessment. FHSD convenes a child obesity workgroup which focuses on the early child population since DOH efforts to date have been targeted largely on school age children and adults. The workgroup is led by WIC and the state Early Childhood Comprehensive Systems Coordinator. The focus on early childhood also reflects the integration of a life course approach.

Healthy Hawaii Initiative (HHI) is the DOH lead to promote healthy lifestyles using Tobacco Master Settlement funds. HHI's purpose is to reduce the burden of chronic disease by promoting physical activity, healthy eating and living tobacco free. HHI led the effort to complete the Hawaii Physical Activity and Nutrition (PAN) Plan and funds coalitions statewide to assure the plan implementation. The plan includes strategies across the lifespan including young children. In 2010 a Supplement to the PAN plan was completed focusing on breastfeeding promotion and reducing screen time, consumption of sugar sweetened beverages (SSB), and energy dense foods.

Several child obesity prevention bills were introduced the 2011 Legislative session. The new Governor supported a tax on SSBs. Another bill would pilot programs to support provider reimbursements to treat child obesity. The Senate Health Committee also held an informational hearing on child obesity. Although the bills failed to pass, there is increased awareness of the problem. The Title V agency informed and educated early childhood providers about the legislation and partnered with HHI to develop a DOH presentation for the Senate informational hearing.

DOH also launched a new public-awareness campaign warning consumers "Don't Drink Yourself Fat," about SSBs. The series of TV ads is supported through the Kauai and Maui District Health Offices using funding from their CDC Communities Putting Prevention to Work (CPPW) grants to address obesity across the lifespan.

The Hawaii Initiative for Childhood Obesity Research and Education (HICORE) is based at the Pediatrics Department at the University Medical School and provides leadership in research and education on childhood obesity. HICORE in collaboration with HHI developed a new health education campaign to prevent childhood obesity, "Hawaii 5210, Let's Go!" The 5-2-1-0 message promotes healthy behaviors including 5 servings of fruits and vegetables, no more than 2 hours of screen time, 1 hour of physical activity daily and 0 or almost none sugar-sweetened beverages (SSB).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide education and support on appropriate dietary practices and physical activity.	X			
2. Access weight and height of children every 6 months at all WIC certifications.	X			
3. Provide information on dietary guidelines to professionals and the public.		X	X	
4. Promote healthy lifestyles through public education campaigns.			X	
5. Provide training for WIC/pediatric providers to improve weight related behaviors of families with young children.				X
6. Collect data on BMI on WIC low-income children.				X
7. Promote partnership and collaboration among PAN and early childhood stakeholders.				X
8. Work with partners to implement the State Physical Activity and Nutrition (PAN) Plan and Supplement in areas concerning young children.				X
9. Develop state capacity to analyze WIC data for the Pediatric Nutrition Surveillance System.				X
10. Advocate for policies that promote health community design and active transportation.				X

b. Current Activities

WIC will continue to use and distribute the children's book "Move 'Um". WIC also continues to give families the Sesame Workshop's "Healthy Habits for Life" kit and coordinate with early child care centers to ensure a consistent message.

WIC continues to encourage consumption of healthy foods as part of a healthy lifestyle for families. WIC will complete updating the WIC Allowed Foods List to incorporate a wider brand selection of whole grains and baby food.

HICORE will collaborate with community partners to develop a strategy to disseminate the 5-2-1-0 message broadly, using electronic and social media.

The Title V Obesity Prevention Workgroup has been meeting to address issues facing childhood obesity. With support from the Governor who recognized early childhood as a critical engagement point to address childhood obesity and diabetes prevention, legislation to support an Obesity Prevention Task Force and funding for early childhood obesity was introduced and supported this legislative session. No SSB tax legislation was proposed this year largely due to strong opposition from the beverage industry.

The DOH is represented on the Advisory Committee for the 5-year \$24.8M USDA grant awarded to UH Manoa for the Children's Healthy Living Program (CHIL) for Remote Underserved Minority Populations to develop nutrition and physical activity intervention, training, monitoring and evaluation systems to guide children's obesity prevention programs in Hawaii and the Pacific.

c. Plan for the Coming Year

Although the national PedNSS dataset will no longer be supported by the CDC, WIC will continue to collect BMI data and will work with the CDC-assigned epidemiologist to develop capacity to conduct the data analysis locally. Objectives for this measure were changed to reflect a 5 percent improvement from the 2011 annual indicator.

In 2010, CDC issued: Use of World Health Organization and CDC Growth Charts for Children Aged 0-59 months in the United States (MMWR 2010; 59; No. RR-9). The CDC recommends the use of the World Health Organization (WHO) growth standards for infants and children birth to 24 months of age. In addition, the National Center for Health Statistics published: Changes in Terminology for Childhood Overweight and Obesity (National Health Statistics Reports; No. 25; 2010). As the title implies, the terminology to categorize a child's weight status has changed. Hawaii WIC will begin utilizing the new CDC growth charts for infants and children less than 24 months of age (based on WHO 2006 Growth Charts) in October 2012.

WIC will also be promoting the new USDA FNS core nutrition messages and resources to motivate moms to offer whole grains, low-fat milk and fruits and vegetable as part of family meals and snacks.

With funding from the legislature and support for a task force, DOH can implement strategies outlined in the HHI Physical Activity and Nutrition Plan and Supplement in areas focusing on early childhood. The Task Force will be addressing multiple factors that lead to obesity and will develop recommendations for policy by the next legislative session. Funding will be used to support existing work that focus on breastfeeding promotion, training to early childhood practitioners using the IMIL curriculum, and for data surveillance. For more information on statewide child obesity efforts since SPM 4.

The CDC, Division of Nutrition, Physical Activity and Obesity (DNPA) in conjunction with the Department of Health and Human Services, conducted regional trainings for states to review its "State Guide to Address Childhood Obesity in the Early Care and Education Setting." Hawaii participated via teleconference into the training to include key stakeholders in the discussion. Representatives from DOH, DHS Child Care Administration, Head Start Collaboration Office, and 2 Hawaii Head Start grantees, attended the training. It is expected that this group will continue to meet to address utilizing the CDC guidance.

Honolulu County and other neighbor island counties have supported the passage of Complete Streets Ordinances to make street design safer for all roadway users. The DOH recognizes the importance of the Built Environment as a key obesity prevention strategy and supports advocacy efforts like these that promote healthy community design. DOH also partners with the Department of Transportation's Safe Routes to School to promote efforts to make walking and biking to school safer for young children.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	8	7	6.8	6.5	6.2
Annual Indicator	8.4	8.5	9.6	7.8	7.8
Numerator	1548	1592	1738	1441	1441
Denominator	18504	18626	18018	18371	18371
Data Source		Hawaii State Department of Health			
Check this box if you cannot report the numerator because 1. There are fewer than					

5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	7	7	7	7	7

Notes - 2011

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.

Notes - 2010

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 2009 is the latest available data for women who smoke in the last 3 months of pregnancy and was carried forward to 2010. 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.

Notes - 2009

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 2008 is the latest available data for women who smoke in the last 3 months of pregnancy and was carried forward to 2009.

a. Last Year's Accomplishments

Smoking is the single largest known preventable risk factor for poor pregnancy outcomes. The 2010 data (latest available data) indicates 7.8% of pregnant women reported smoking during pregnancy. The State objective of 6.5% and the Healthy People 2020 Objective of 1.4% were not met.

According to Hawaii PRAMS data from 2009-10, of the women who smoked prior to pregnancy, 39.8% smoked during the last trimester pregnancy and 58.5% reported smoking 2-9 months postpartum.

Title V administers the Perinatal Support Services (PSS) program with contract providers throughout the State. Services include outreach, risk assessments/screenings, health education, and case management for high-risk pregnant and post partum women. PSS providers screen and assess smoking behaviors and refer for smoking cessation counseling.

The Title V Perinatal Support Services and Triage (PSST) program provides support services to pregnant women with substance abuse, including smoking. Due to 2009 budget cuts the program was eliminated. New funding became available in 2011 contracts were awarded to the Waikiki Community Health Center-PATH Clinic, a substance use treatment program for pregnant women and the Waianae Coast Comp Health Center, serving rural Oahu.

The Department of Health (DOH) Basic Tobacco Intervention Skills Certification Program was established to increase screening and smoking cessation counseling skills of health professionals using the 5 A's Tobacco Cessation Counseling Guidelines (Ask, Advise, Assess, Assist, and Arrange).

The WIC program continues to screen pregnant women and mothers using the 5 A's guidelines and refers pregnant and parenting women to the DOH statewide Tobacco Quitline and community health centers for smoking cessation classes and interventions.

The federally funded Healthy Start Big Island Perinatal Health Disparities program (BIPHDP) provides perinatal support services to high-risk pregnant women up on the island of Hawaii. Target populations include women of Hawaiian, Other Pacific Islander, Hispanic, and Filipino ancestry and adolescents. The program is designed to decrease the incidence of poor birth outcomes and includes screening for smoking and refers for smoking cessation.

The Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii provides system building support to improve statewide perinatal services and also coordinates the statewide Perinatal Advocacy Network (PAN) meetings. HMHB works with MCHB to support quarterly Perinatal provider meetings. HMHB also provides health messaging through the pregnancy resource, referral, information phoneline, website and "Text4baby" program.

HMHB was awarded a federal Healthy Care grant in November 2010. The grant objectives are to promote awareness of available resources and the importance of life span health among expectant parents. Activities include dissemination of messages through social media and working with/training community "ambassadors".

DOH Tobacco Prevention and Education Program (TPEP) developed a bus card, adapted from the American Legacy Foundation, "Great Start" campaign to promote smoking cessation among pregnant and postpartum women. A brochure, "Stop Smoking For a Healthy Baby," was distributed statewide.

The Hawaii Tobacco Prevention and Control Trust Fund Health Communications Project had a campaign to include creating effective messages to target pregnant women who smoke. The Tobacco Trust Fund Project Team convened focus groups to assist with the campaign and to promote use of the Quitline.

TPEP and the Tobacco-Free Coalitions provide leadership for smoking prevention efforts by changing knowledge, attitudes and practices of adults and youth regarding smoking and facilitate implementation of the Statewide Tobacco Control Strategic Plan.

DOH Healthy Hawaii Initiative (HHI) and chronic disease prevention program were awarded a CDC ARRA-funded Communities Putting Prevention to Work State Initiative grant to expand promotion efforts for the Hawaii Tobacco Quitline.

The Perinatal Smoking Workgroup (PSW) convenes key public and private smoking prevention and perinatal stakeholders to build partnerships, share data and resource information, and collaborate on program planning.

A perinatal smoking panel presented issues related to prenatal smoking at the Statewide Tobacco conference in November with the intent to raise awareness of smoking during pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. Conduct the Pregnancy Risk Assessment Monitoring Survey (PRAMS) to collect, analyze and disseminate data on tobacco use before, during and after pregnancy.				X
2. Execute and administer contracts for perinatal support services to provide outreach, risk assessments, and referrals to high-risk pregnant women.	X	X		X
3. Provide outreach and support services during pregnancy and 2 year interconception period through the Hawaii County Perinatal Disparities Grant for risk groups. Services address risk factors for tobacco and other substance use.	X	X		X
4. Execute and administer contracts to enhance the statewide perinatal system of care through assessment and advocacy; pregnancy resource referral and information (phone line and website); and, perinatal provider education and training.		X	X	X
5. Provide screening and referral for WIC low income perinatal clients who use substances including tobacco.		X		
6. Support training on smoking cessation interventions for perinatal service providers.		X		
7. Convene Prenatal Smoking Workgroup to continue to promote strategies that work in smoking cessation for women before, during and after pregnancy.				X
8. Collaborate on effective strategies to reduce smoking during and after pregnancy as part of the State Tobacco Use and Prevention Plan (e.g. media, counter marketing campaigns, policies for smoking prevention and control use).				X
9. Operate the statewide toll-free smokers Quit Line.			X	X
10.				

b. Current Activities

The PSS, PSST, Healthy Start BIPHDP, and WIC programs continue to screen prenatal women for smoking behaviors and refer for smoking cessation.

HMHB continues to promote maternal health and provide system building support to improve perinatal services. Using funding from the Healthy Care Grant, HMHB launched a marketing campaign to publicize resources available to support healthy pregnancies and early newborn care. Funding for the Healthy Care grant will end this fiscal year due to Federal funding restrictions.

The TPEP and Tobacco Free Coalitions on five islands will continue with ongoing statewide smoking cessation activities. Hawaii is one of a few states that continues to use a portion of the Tobacco Settlement funds for tobacco prevention. The Hawaii efforts are directed at large scale community norm changes that include policy change, community education, media/countermarketing, resulting in the 8th lowest smoking rate among adults in the U.S.

Imi Hale program, a consortium of Native Hawaiian health organizations, is participating with the University of Connecticut and Harvard on a project to determine the effectiveness of warning messages targeting prenatal women on cigarette packages.

The PSW continues to meet quarterly. Data for PRAMS will be updated next year. In 2012, Hawaii PRAMS entered into a partnership with the TPEP resulting in multiple projects, conference and other presentations.

c. Plan for the Coming Year

Data for PRAMS will be updated next year. The annual performance objectives were revised to reflect a 5 percent improvement based on the 2011 annual indicator.

The PSS, PSST, WIC, and the Healthy Start BIPHDP programs will continue services and provide referrals for smoking cessation. The PSS program will collect data on relapse of smoking post-partum and ensure services are provided to clients who stopped smoking during their pregnancy into the post-partum period.

HMHB will continue to conduct needs assessments to identify statewide PNC needs, coordinate PSS provider education and meetings, and manage the pregnancy resource, referral and information, phonenumber and website. All of these services provide system building support to promote maternal health and improve perinatal services including smoking prevention and cessation. Upcoming trainings will include brief intervention and motivational interviewing for the PSS providers which can be utilized to address smoking behaviors.

The PSW will continue to meet and discuss opportunities to build partnerships, monitor data, increase public awareness on the dangers of smoking in pregnancy, improve the availability of smoking cessation resources for pregnant women and their families, and collaborate on program planning.

TPEP has designated the perinatal population as a disparity group in its Annual Action Plan and will work more closely with MCHB in supporting data collection and analysis to stimulate new community programs and grant applications.

The DOH and its programs including Title V have been identified as key partners in a Children's Research Triangle (CRT) -Hawaii project. CRT received a Hawaii Community Foundation grant to expand its Big Island substance use screening program on Hawaii island to Oahu and develop a comprehensive system of care for pregnant women who are using alcohol, tobacco, or illicit drugs. Title V staff will participate in a September 2012 Leadership Institute to discuss substance use services for pregnant women. Next steps for implementation of the CRT prevention and intervention program at 6 Oahu community health centers will reviewed.

PRAMS revised survey will be implemented during 2012. Survey questions will continue to assess smoking behaviors before, during, and after pregnancy. Additionally, the revised survey may include a question on the reasons that affect a women's decision to stop smoking.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	8	8	7	7	7
Annual Indicator	10.6	10.6	11.6	13.0	12.0
Numerator	26	26	28	32	30
Denominator	244971	244971	242111	246609	249437
Data Source		Hawaii State Vital records			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of					

events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	11	11	11	11	11

Notes - 2011

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.

Notes - 2010

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 2009 was revised with an updated death data file. Data for the year 2010 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, 2009" (SC-EST2009-AGESEX_RES). Previous years have been revised based on revised population estimates. Estimates for the 2010 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.

Notes - 2009

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 2008 was revised with an updated death data file. Data for the year 2009 is provisional. Population data based 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, 2008" (SC-EST2007-AGESEX_RES) (May 1, 2009). Estimates for the 2009 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 in 2009 is the same as was used in 2008 and reflects population estimates for youths aged 15 through 19 years of age in 2006-2008.

a. Last Year's Accomplishments

The provisional data for 2011 is 12.0 suicide deaths per 100,000 youth aged 15-19. The state objective was not met. The 3 year rolling average rates of suicide have increased slightly from 8.2 reported for FY 2006 to 12.0 for FY 2012.

Youth Risk Behavioral Survey (YRBS) data continues to show Hawaii youth consider suicide

more often than their mainland counterparts. In 2011, 16.1% of Hawaii's high school youth reported seriously considering attempting suicide, a slight decrease from 18.9% in 2009, with Hawaii having the highest ranking for suicide ideation in the U.S. The state also has had the 9th highest rate of teens reporting suicide attempts (8.6%) and the second highest percentage reporting making a suicide plan (15%). The DOH and DOE will continue to support surveillance instruments on adolescent behavior for public high and middle school students, including questions regarding suicidal thoughts and behavior as well as protective factors.

The Prevent Suicide Hawaii Task Force (PSHTF) remains under the guidance of the DOH's Injury Prevention Control Section (IPCS). The mission of PSHTF is to prevent suicide by raising awareness, eliminating stigma, and supporting those at risk of, or affected by, suicide. Membership includes public and private agency members such as the Department of Education (DOE), Honolulu Police Department (HPD), the University of Hawaii, the DOH Child and Adult Mental Health Divisions, Emergency Medical Services (EMS) and others interested in suicide prevention. The Adolescent Health Coordinator represents Title V on the task force.

PSHTF efforts will continue to focus on building capacity for suicide prevention activities and sustain training in the neighbor island counties. An example of neighbor island task force activities includes a consortium of safeTALK trainers on Hawaii Island. The intent of this group is to collaborate with community-based agencies to have safeTALK become an integral part of communities, including within the DOE system. In Maui County, agencies will set up a network of suicide prevention trainings throughout the year.

The annual 2011 suicide awareness and prevention conference, "Families and Community Partners Healing," was co-sponsored by the DOH, Hawaii's Suicide Prevention Education Action Resources (SPEAR), Queen Liliuokalani Children's Center and the PSHTF.

The IPSC continue to distribute a free teen suicide prevention brochure and poster authored by an adolescent, "Let's Talk About It!" to schools and community groups.

Harm Reduction Hawaii (HRH) sponsored the "Transitioning in Hawaii" conference on transgendered issues. HRH is a coalition of individuals and agencies working toward the implementation of effective and respectful services to improve the health of drug users and other marginalized people.

A 3-year Hawaii Gatekeeper Training Initiative ended. This SAMHSA grant provided Gatekeeper training focusing on community members who work with youth. More than 500 persons in key agencies like the police, mental health workers, and school counselors were trained in either safeTALK or ASIST, the Applied Suicide Intervention Skills training. A suicide prevention training sustainability plan was developed by the PSHTF to ensure training efforts in the state continue.

The John A. Burns School of Medicine at University of Hawaii received a SAMHSA Youth Suicide Prevention Grant. The UH School of Psychiatry will administrator of the grant which will continue to support training and prevention initiatives.

The IPCS updated the Hawai'i Injury Prevention Plan (HIPP) for 2011-2015. The HIPP features a section on suicide prevention and includes state suicide data. While the teen suicide rates have not increased, trend data is showing that suicides are increasing in this state for adults, particularly among those over 50. The PSHTF and other community-based groups continue to work with IPCS to strengthen the State's infrastructure to prevent suicides.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Provide suicide prevention education to students and the community.			X	
2. Implement the suicide prevention recommendations of the 2011-2015 Hawaii Injury Prevention Plan.				X
3. Develop greater coordination and collaboration to address suicide prevention.				X
4. Identify suicide prevention strategies by reviewing information surrounding child/adolescent suicide-related deaths.				X
5. Provide training to promote healthy youth development and suicide prevention efforts.				X
6. Support the surveillance systems through administration of the YRBS in High School and Middle School students to collect student health data used for program planning.				X
7. Promote increased awareness and education of suicide as a health problem, remove the stigma, identify those at-risk and provide support to survivors.			X	X
8. Support continued research into evidence-based practices and secure resources to expand services.				X
9. Support Prevent Suicide Hawaii Task Force efforts to develop and address adolescent suicide prevention.				X
10.				

b. Current Activities

The University of Hawaii's SAMHSA grant, Hawaii's Caring Communities Initiative (HCCI), will build on the gatekeeper training efforts supported through a previous SAHMSA grant. The grant will focus on youth from rural and Native Hawaiian communities who are at higher suicide risk. HCCI's first project is using a primary prevention, community-based, and youth-driven program, "Connect", in the rural Oahu communities of Waimanalo and Kahuku and on the island of Kauai. The second project utilizes a secondary/tertiary prevention approach to work with emergency departments and trauma centers.

The newly formed Oahu PSHTF continues to meet monthly at the Queen Liliuokalani Children's Center. Committee work has begun to focus on increasing: public awareness of SP issues; networking and coordinating resources; and education/training.

Hawaii Youth Services Network (HYSN) contracted IPCS to coordinate the facilitation of a series of Gatekeeper trainings on Oahu and the neighbor islands on March 2012 (10 ASIST trainings; 12 safeTALK trainings). IPCS staff will also support the existing trainers who are conducting the ASIST and safeTALK trainings statewide.

A subcommittee of the PSHTF will increase efforts to raise awareness among schools about suicide risk and suicide prevention and develop policies to support teachers and other school staff to understand their role as gatekeepers to prevent suicide among students.

c. Plan for the Coming Year

Provisional data will be updated. The annual performance objectives were revised to reflect a 5 percent improvement from the 2011 annual indicator.

PSHTF will continue to address suicide prevention at the State level through the neighbor island task force chairs. The PSHTF steering committee will send a PHTF team to participate in neighbor islands meetings once per year. The team will consist of the PHTF Chair, the Chair-Elect and the IPCS Coordinator.

Neighbor island PSHTF chairs shared their experience of the DOH Adult Mental Health Division

(AMHD) 24-hour, toll-free ACCESS Line that provides assistance to the public to address mental health crisis situations. IPCS and ACCESS Line staff will be working to review and improve ACCESS Line availability given new technologies that could impact how services are delivered and utilized by clients.

The Hawaii's Caring Communities Initiative (HCCI) focuses on improving access to care and reducing mental health disparities in rural communities. This year's activities will include the addition of Hilo's First United Protestant Church and 6 trauma centers into their projects. Mobilizing Communities At-Risk (MCAR) will be utilized with existing community sites. The program uses a youth and community mobilization model to engage youth in suicide prevention advocacy. The Enhancing the Statewide Trauma Network (ESTN) program provides community emergency departments/trauma centers with a new avenue for training gatekeepers who have frequent contact with youth who are suicidal or have made suicide attempts.

IPCS is contracting Mental Health America of Hawaii to develop a public awareness campaign to address youth at risk for suicide. Focus groups will test messages developed for the target audience. A final report will include recommendations and dissemination strategies.

IPCS has funding from DOH Child and Adolescent Mental Health Division to host Mary Jadwisiak, a consultant from Washington state, who has experience with providing a wide range of trainings, consultations and technical support in mental health recovery and suicide prevention. She will be speaking to psychiatric residents at several hospital as well as conducting sessions for suicide and mental health professionals statewide.

IPCS has taken a leadership role to collaborate with legislators and public and private agencies to address risk for bullying and suicide among Hawaii school students and other issues related to youth at-risk. These efforts will continue next year.

IPCS staff will present and a conduct skills building session on suicide prevention at the Global Public Health and the Harm Reduction conferences, both scheduled for October 2012.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	88.5	89	89.5	90	90
Annual Indicator	89.5	84.7	88.6	95.4	90.9
Numerator	205	199	233	209	209
Denominator	229	235	263	219	230
Data Source		Hawai'i State Vital records			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016

Annual Performance Objective	95	95	95	95	95
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Notes - 2011

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.

Notes - 2010

Data is for resident population and is by calendar year. Data for the year 2009 was revised with an updated birth data file. Data for the year 2010 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 determination of annual performance objectives beyond the year 2010 is on hold pending a comprehensive reassessment and critique of the indicator's past performance, issues and resources affecting the measure, and the release on the new Healthy People 2020 objectives.

Notes - 2009

Data is for resident population and is by calendar year. Data for the year 2008 was revised with an updated birth data file. Data for the year 2009 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 determination of annual performance objectives beyond the year 2010 is on hold pending a comprehensive reassessment and critique of the indicator's past performance, issues and resources affecting the measure, and the release on the new Healthy People 2020 objectives.

a. Last Year's Accomplishments

Provisional data for 2011 report 90.9 % of VLBW infants were delivered at facilities for high-risk deliveries and neonates. The objective was met and exceeded the Healthy People 2020 Objective of 83.7%. Although the rate did decrease from last year, the data is provisional.

Kapiolani Medical Center for Women and Children (KMCWC) is a private, non-profit, tertiary care facility specializing in gynecological, obstetrical, newborn and pediatric care. It is located on Oahu and has the largest delivery service in Hawaii. KMCWC is the only hospital providing Level III care to the general population with a 46 bed Neonatal Intensive Care Unit (NICU).

The other hospitals reporting Level III NICU are also located on Oahu: Kaiser Medical Center which provides services only to subscribers of its health plan; and Tripler Army Medical Center (TAMC), which provides obstetrical care for the military population as well as referral for care for military and civilian patients from the Pacific islands and Asia. TAMC has a 16 bed NICU which admits approximately 300 infants annually.

The KMCWC Neonatal Transport Program is responsible for managing the transport of infants from other hospitals on Oahu and on other islands, as well as from Hawaii to the Mainland. Specially trained staff transport critically ill infants to Honolulu with the air ambulance service.

DOH Emergency Medical Services & Injury Prevention System Branch administers the Emergency Medical Services for Children (EMSC) State Partnership grant. The grant supports 2 projects that improve the emergency transport system of VLBW babies: the Neonatal Resuscitation Teams (NRT) program and Emergency Pediatric Care (EPC) course. The NRT program is managed through the Hawaii Island Collaborative Health Initiative (HI-CHI). The HI-CHI is comprised of varying healthcare providers, advocates, neighbor island partner hospitals,

and KMCWC. HI-CHI's goal is to assure there are trained neonatal resuscitation teams in every neighbor island hospital. Current participating neighbor island hospitals are: Hilo Medical Center; Kona Medical Center; North Hawaii Community Hospital and Maui Memorial Medical Center.

The Emergency Pediatric Care (EPC) course is offered through the University of Hawaii Community College Emergency Medical Services continuing education to licensed EMS providers statewide. The EPC provides an in-depth understanding of the pathophysiology of the most common newborn, infant and pediatric emergency issues, and stresses critical thinking skills to help practitioners make the best decisions for their patients while incorporating a family centered care throughout all scenarios. The EPC program empowers EMS providers with greater skills to provide newborn delivery and stabilization and to provide a support role for the KMCWC Transport Team and Hawaii Life Flight during the patient transport. The EPC course is regularly offered on the islands of Oahu, Kauai and Maui.

Hawaii Life Flight provides air ambulance medical transport from all neighbor island hospitals to Oahu, including obstetrical emergencies requiring a Level III NICU. There is an air ambulance and medical crew based strategically across the State to transport medical emergencies within 20 minutes of a call. The air ambulance bases are located in Hilo, Waimea and Kona on the Big Island; Lihue, Kauai; and Kahului, Maui. The Maui base serves Molokai and Lanai as well. The main base for Hawaii Life Flight is on Oahu, which can dispatch extra services to the neighbor islands and to rural areas of Oahu as needed.

Title V programs work to reduce preterm births and VLBW infants targeting services primarily to high-risk pregnant women. Programs provide case management and help assure prenatal appointments are kept. Programs include the Perinatal Support Service (PSS) with contracted providers throughout the State that conduct outreach, risk assessments /screenings, health education, and case-management to high-risk pregnant women up to 6 months post-partum. The federally funded Healthy Start Big Island Perinatal Health Disparities (BIDHP) program provides perinatal support services to high- risk pregnant women on the island of Hawaii.

Title V supports infrastructure building services through contracts with Healthy Mothers, Health Babies Coalition of Hawaii (HMHB) to provide system building support and coordinate Perinatal Advocacy Network meetings to discuss issues impacting services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect, analyze, and disseminate Hawaii data from the Pregnancy Risk Assessment Monitoring Survey (PRAMS).			X	X
2. Administer contracts for perinatal support services to assure access to services for high-risk pregnant women statewide.	X	X		X
3. Administer the federal HRSA grant for the Big Island Perinatal Disparities program to provide outreach and support services for high-risk pregnant women to assure access to care and reduce poor birth outcomes like low birth weight.	X	X		X
4. Administer contracts to enhance the statewide perinatal system of care through assessment and advocacy; pregnancy resource referral and information (phone line and website); and perinatal provider education and training.		X	X	X
5. Assure access from the neighbor islands to tertiary care centers through the air ambulance system.				X
6. Support efforts to improve coordination and collaboration among perinatal providers.				X
7. Promote partnerships to assess, address and improve upon				X

policies and practices which can positively impact perinatal, prenatal health services and high risk deliveries.				
8. Coordinate a Prenatal Health Summit with stakeholders on the island of Hawaii.				X
9. Provide ongoing training for emergency medical service providers to safety transport critically ill infants.				X
10.				

b. Current Activities

Program activities to reduce preterm births and VLBW infants continue. Refer to NPM 15 and 18 for information on prenatal substance use and promoting early prenatal care. KMCWC and its Neonatal Transport team, Kaiser Medical Center, and TAMC continue to provide medical services to very low birth weight infants at their NICUs. The Hawaii Air Ambulance continues to support the KMCWC Neonatal Transport Team by transporting critically ill infants to Honolulu.

HMHB, MCHB and MCH liaisons on the neighbor islands facilitated meetings with community partners for ongoing assessments on MCH and women's health needs, including access to prenatal care. Information from these meetings was analyzed by HMHB and Maternal Child Health Branch (MCHB). HMHB worked with communities to prioritize their needs and provided grant opportunities to address them.

DOH, MCHB will coordinate a Prenatal Health Summit with the stakeholders on the island of Hawaii. The summit will be to address the emerging critical issues, put into action local health system action plans, and revitalize the Big Island Consortia..

Research projects using Hawaii PRAMS data were presented at the Maternal and Child Health Epidemiology Conference in New Orleans, LA in December 2011. Presentations were given on risk factors associated with Small for Gestational Age (SGA) deliveries.

The revised Hawaii PRAMS survey rolled out in 2012 and included questions on preterm delivery and pregnancy risk behaviors related to VLBW.

c. Plan for the Coming Year

Provisional data for 2010 will be updated. The annual performance objective for the years 2012 to 2016 were revised to reflect a 5% improvement from the 2011 indicator.

Refer to NPM 15, NPM 18, and SPM 02 for programs and activities to promote women's health and reduce preterm births and LBW infants.

KMCWC and its Neonatal Transport team, Kaiser Medical Center, and TAMC continue with providing medical services to very low birth weight infants at their NICU.

The four Hawaii County Local Area Consortia continue to meet and focus on efforts to improve the perinatal health care system.

As a result of the Prenatal Health Summit, a three month follow-up meeting and activities will be put into place and implemented to support the perinatal needs of the Big Island

HMHB continues its role in working with the MCHB in brokering partnerships and initiating ongoing assessments in Perinatal Advocacy Network activities with women and perinatal health stakeholders. More details are included in NPM 18.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	83	84	85	86	86
Annual Indicator	77.9	79.9	78.8	78.8	81.2
Numerator	14868	15514	14853	14900	15358
Denominator	19086	19408	18843	18911	18907
Data Source		Hawai'i State Vital records			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	86	86	86	86	86

Notes - 2011

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.

Notes - 2010

Data is for resident population and is by calendar year. Data for the year 2009 was revised with an updated birth data file. Data for the year 2010 is based on a provisional birth data file.

Notes - 2009

Data is for resident population and is by calendar year. Data for the year 2008 was revised with an updated birth data file. Data for the year 2009 is based on a provisional birth data file.

a. Last Year's Accomplishments

Provisional data for 2011 indicates 81.2% of pregnant women received first trimester prenatal care (PNC). The State objective of 86% was not met, however, the Healthy People 2020 objective of 77.9% was met. Rates have remained relatively stable for the past 7 years.

Title V administers the Perinatal Support Services (PSS) Program with contract providers throughout the State. The PSS providers conduct outreach, risk assessment/screenings, health education, 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.

The Perinatal Support Services & Triage program provides services to pregnant women identified to have a substance abuse problem in their efforts to abstain from alcohol, tobacco and illicit drug use during pregnancy and through six months post-partum. The program promotes early PNC for this high risk population. These services started in July 2011 at two Oahu sites Waianae Coast Comprehensive Health Services, Oahu's largest community health center (CHC), and the Waikiki Health Center PATH Clinic (which serves substance using pregnant women).

The Kalihi Palama Health Center (KPHC) on Oahu had used the CenteringPregnancy group

method to support ongoing PNC for immigrant, high-risk populations. There had been a separate group for Chuukese speaking women from Micronesia. CenteringPregnancy groups were placed on hold in 2011 due to shortage of certified nurse midwives but there continues to be interest from the KPHC in continuing this program if this workforce situation improves.

The federally funded Healthy Start Big Island Health Disparities Program (BIHDP) employs Neighborhood Women to conduct community outreach and perinatal support services to high-risk pregnant women. Services are provided for 2 years during the interconception period. Certain Hawaii County communities and populations are at-high risk for poor perinatal outcomes (including low rates of early PNC), worsened by challenging access to care issues as the largest rural island in the State. The program targets women of Native Hawaiian, Other Pacific Islander, Filipino, Hispanic ancestry as well as adolescents. One of the program objectives is to increase PNC in the first trimester. There is a higher reimbursement rate for this enrollment.

The BIDHP helped form 4 Local Area Consortia that also serve a broader purpose to improve the Hawaii County perinatal health care system and implement actions such as increasing access to care.

Hawaii Covering Kids initiated a Pregnant Women Mailout Campaign sending postcards with insurance information for pregnant women of specific income levels to 90,000 households.

Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii conducts needs assessments in coordination with the Title V MCH Branch (MCHB) to identify statewide PNC needs such as barriers to first trimester care. Statewide quarterly Perinatal Provider Advocacy Network (PAN) meetings are held to facilitate these discussions on legislation or perinatal service issues. HMHB works with MCHB to plan the quarterly PSS provider meetings to offer training and a platform to share strategies to assure early and ongoing PNC by improving outreach and case management. HMHB also manages the pregnancy referral and information phone line, "Text4baby", and website that includes information on PNC.

HMHB was awarded the federal Healthy Care Grant in November 2010 to increase expectant parents' awareness of resources before, during, and after pregnancy and the importance of life span health. Information will be disseminated by social media and community leaders.

In October 2010 Hawaii PRAMS released the 2000-2008 Trend Report. The report includes PNC data showing those living in Kauai, Maui and Hawaii counties had lower rates of PNC compared to those living in Honolulu. The report also identified other at-risk groups including those of Samoan, Hawaiian and "Other Pacific Islander" race; and those under 25 years of age. Individual PRAMS Trend Reports were developed for each neighbor island county in April 2011.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Facilitate ongoing assessment of access into prenatal care through use of vital statistics, PRAMS, Perinatal Support Service programs, federal Healthy Start Perinatal Disparities Project program data.				X
2. Administer contracts for prenatal support services to high-risk pregnant women statewide to promote the importance of entry into first trimester and ongoing prenatal care.	X	X		X
3. Administer the federal Healthy Start grant for the Big Island Perinatal Disparities program to provide outreach and support services for high-risk pregnant women including a focus on entry into first trimester pregnancy and ongoing prenatal care.	X	X		X
4. Provide culturally competent service delivery through a variety	X	X	X	X

of sources in areas with populations of higher risk women to improve birth outcomes.				
5. Administer contracts to enhance the statewide perinatal system of care through assessment and advocacy; pregnancy resource referral and information (phone line and website); and perinatal provider education and training.		X	X	X
6. Facilitate community engagement by supporting the formation of local organizations (consortiums) to increase access to first trimester perinatal care and improve system-wide service delivery in Hawaii County.				X
7. Continue state perinatal partnerships for assessment and advocacy to improve first trimester prenatal care access issues.				X
8. Coordinate a Perinatal Health Issues Summit with stakeholders on the island of Hawaii to help improve the system of perinatal services and birth outcomes.				X
9.				
10.				

b. Current Activities

All PSS, PSST, and Healthy Start BIPHDP programs continue to promote early PNC through outreach to high risk women. The PATH Clinic services will expand to include pediatric and primary care services.

HMHB, MCHB and MCH liaisons on the neighbor islands facilitated meetings with community partners for ongoing assessments on MCH and women's health needs, including access to care. MCHB and HMHB analyzed this information to help communities prioritize their needs and then provide grant opportunities to address them.

HMHB will launch a marketing campaign which will include media advertising, a resource directory, a redesigned website, topic brochures, slogan contest and an E-newsletter using the Healthy Care grant. Through these media, information on the importance of PNC will be promoted. The grant will end this year due to Federal funding restrictions.

MCHB will coordinate the Hawaii Island Perinatal Health Action Summit with the stakeholders on the island of Hawaii in August and a follow-up meeting in November. The Summit is designed to address emerging critical issues (particularly provider shortages); support implementation of local health system action plans; and energize the BIDHP Local Area Consortia.

The DOH Primary Care Office is surveying primary care providers, including OB/GYNs, to renew existing Health Professional Shortage Area designations located largely on the neighbor islands.

c. Plan for the Coming Year

The annual performance objectives were changed to reflect a 5 percent improvement from the state 2010 annual indicator.

All PSS, PSST, and Healthy Start BIPHDP programs will continue to promote early prenatal care by outreach to high risk women.

With signs that the state economy is slowly improving, an Administrative bill was introduced in the 2012 Legislature to restore short-term funding for DOH programs affected by past budget restrictions, including PSST. PSST was identified as a priority program for funding in the bill. It will not be known until July 2012 whether funding will be restored for the next fiscal year.

HMHB will continue to conduct needs assessments to identify statewide PNC needs; coordinate PSS provider education and meetings; conduct statewide Perinatal Advocacy Network meetings

to facilitate coordination and initiatives to improve perinatal care, including legislation; and manage its pregnancy resource, referral and information, phoneline, website, and facebook page. HMHB will continue to provide Text4Baby, however, the service will no longer be able to provide local referral phone numbers.

The four BIDHP Hawaii County Local Area Consortia continue to meet and focus on efforts to improve the perinatal health care system and access to care including first trimester care.

A three month follow-up meeting to the Hawaii Island Prenatal Health Action Summit is planned to provide support and assure action plan activities are implemented to improve perinatal services on the Big Island. The state Office of Rural Health is supporting the Prenatal Summit as a key partner.

MCHB will be provided CDC Preventive Health and Health Services Block Grant funding for CenteringPregnancy provider training to increase workforce competency in this area and improve adequacy of prenatal care through this innovative/support centered model of care. The funding will also be used to complete an assessment of the State's 11 birthing facilities and their policies related to early-term, non-medically necessary inductions before 39 weeks.

The DOH Primary Care Office will continue to survey primary care providers, including OB/GYNs, to renew existing Health Professional Shortage Area (HPSA) designations or develop new designations. Three of the 6 state primary care HPSAs are located on the Big Island.

PRAMS surveillance will continue and publications updated to increase awareness of issues impacting pregnant women including access to prenatal care and variables such as depression, substance use, intimate partner violence that can influence timely and ongoing health services and receipt of late or no prenatal care.

D. State Performance Measures

State Performance Measure 1: *The percent of pregnancies (live births, fetal deaths, abortions) that are unintended.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	47	46	45	44	43
Annual Indicator	52.9	48.2	53.3	52.9	52.9
Numerator	12108	10982	11972	12083	12083
Denominator	22880	22775	22477	22831	22831
Data Source		Hawaii State Department of Health			
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance	50	50	50	50	50

Objective					
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Notes - 2011

Data for this measure comes from the Hawai'i Pregnancy Risk Assessment Monitoring System (PRAMS) and Hawai'i Vital Statistics. 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 unintendedness 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.

Notes - 2010

Data for this measure comes from the Hawai'i Pregnancy Risk Assessment Monitoring System (PRAMS) and Hawai'i Vital Statistics. Data for the year 2010 was updated with the latest data available from PRAMS. Data from Vital Statistics are from the updated 2010 data files.

PRAMS provides surveillance of unintendedness in pregnancies that resulted in a live birth. The PRAMS rate of unintendedness alone is an underestimate of pregnancies that resulted in a live birth and does not include fetal deaths or abortions. Beginning with the 2010 data year, the Hawaii measure of unintendedness 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. 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. 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).

Data for this measure comes from the Hawai'i Pregnancy Risk Assessment Monitoring System (PRAMS) and Hawai'i Vital Statistics. Data for the year 2009 is the latest data available from PRAMS. Data from Vital Statistics are from the updated 2009 data files.

PRAMS provides surveillance of unintendedness in pregnancies that resulted in a live birth. The PRAMS rate of unintendedness alone is an underestimate of pregnancies that resulted in a live birth and does not include fetal deaths or abortions. For this estimate, the Hawaii measure of unintendedness based on 2 questions was used to be consistent with prior data reported in Title V. The numerator included total number of unintended births (PRAMS), the number of fetal deaths multiplied by the proportion of unintended births (PRAMS), and abortions (Vital Statistics). The denominator is the total number of live births (PRAMS), fetal deaths (Vital Statistics), and abortions (Vital Statistics).

Notes - 2009

Data for this measure comes from the Hawai'i Pregnancy Risk Assessment Monitoring System (PRAMS) and vital statistics. Data for the year 2008 is the latest data available from PRAMS, and

estimates from vital statistics for fetal deaths and abortions are unreliable in provisional estimates available at time of this report so the 2008 vital statistic estimates are used.

PRAMS provides surveillance of unintendedness in pregnancies that resulted in a live birth. The percentage of unintended pregnancies derived from PRAMS is applied to the number of live births and fetal deaths to residents for the year. All abortions are also added to the numerator. The PRAMS rate alone underestimates unintendedness prevalence as it does not include those pregnancies that ended in abortion or fetal death. The denominator for this measure is all live resident births, fetal deaths, and abortions.

a. Last Year's Accomplishments

This measure reflects the State priority to reduce Hawaii's rate of unintended pregnancies. The above 2010 data indicates 52.9% of pregnancies in the State were unintended. The state objective was not met, nor was the Healthy People 2020 Objective of 46%.

Approximately 67,300 women in Hawaii (under 250% of the Federal Poverty level for Hawaii) needed public supported contraceptives and services (Contraceptive Needs and Services, National and State Data, 2008 Update, Guttmacher Institute 2010). Hawaii PRAMS 2010 data reveal that 45.71% of pregnancies resulting in a live birth were unintended about half (48.8%) of women with an unintended pregnancy reported not doing anything to prevent a pregnancy at conception. Unintended pregnancies may be prevented by using effective contraception, but it is not the only factor related to prevention. Reasons for not using contraceptives were: didn't mind if they got pregnant, problems they had getting birth control, their husband/partner did not want to use contraception, concern over side effects, and they did not think they could get pregnant.

Efforts to prevent unintended pregnancy continue by providing greater access to contraception through 37 clinics on all 6 of the major islands with services funded primarily by the federal Title X program. This program is administered by the Family Planning program (FFP) which is part of the Title V agency, MCH Branch (MCHB). Target populations are the uninsured and underinsured; men and women; adolescents; those with limited English proficiency; disparate groups such as homeless, substance users, and low-income individuals. Hawaii service sites include community health centers (CHC), college and university health centers, hospital and community-based nonprofit organizations in rural areas. Sixty five percent of services (11 sites) are offered through CHCs in high need areas. Providers offer outreach, clinical, education, and referral services. Translation, interpretation services, and FP health education materials culturally tailored to meet the needs of various racial/ethnic, geographic, and disparate groups are also provided. FP service referrals for clients from other Title V programs are encouraged.

Both State and federal funds for FP services were cut but client served numbers increased likely due to the addition of one of the largest CHCs serving disparate populations through several clinic sites. In FY 2011, 22,571 clients were provided subsidized FP clinical services (representing over 38,845 clinical visits); of these 39.5% were uninsured with incomes less than 100% of the Federal Poverty Level. Approximately 17.0% of visits (2,553 clients) were for a positive pregnancy test noted as an unplanned pregnancy.

Population-based services are provided through Title X FP community health educators (HE) statewide. Activities include presentations, distribution of educational materials, and health fairs. The goal of the community health educator program is to improve development and dissemination of reproductive health information and access to family planning services to those in need. Based on 2009 funding cuts full-time FP health educator positions were reduced to half time and their scope of work revised. Despite the cuts, 36,122 (individual or group) direct adolescent educational contacts were made in FY 2011.

To support greater provider use of effective Long Acting Reversible Contraception -- LARC (Hormonal implants and Intrauterine devices - IUD) methods, the FFP has continued to receive Title X funds for hormonal implant training/certification and to purchase of supplies. A provider

hormonal implant practicum was held prior to the 2011 FP Reproductive Health Conference.

At the statewide 2011 Annual Family Planning and Reproductive Health Conference there were 115 attendees with approximately 83% from statewide family planning clinics. Updates on current FP issues and practices were provided by local and national speakers.

A Rapid HIV STD Integration project with Title X funding continued with the Waikiki Health Center to improve male outreach and services for HIV and STD reduction with higher risk populations.

In September 2011 a \$25,000 additional continuation grant was received from Title X. This resulted in an agreement with the Domestic Violence Action Center to improve domestic violence, intimate partner violence and intervention services targeting health care providers statewide.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct the Pregnancy Risk Assessment Monitoring Survey (PRAMS) to provide data on unintended pregnancy for needs assessment and program planning.				X
2. Execute and administer family planning contract services to assure access to services for the uninsured, underinsured and other populations of women and males in need statewide.	X	X		X
3. Provide reproductive health education and community-based education contracts targeting at-risk populations.		X	X	X
4. Provide monitoring, technical assistance and training for family planning Title X funded contractors.				X
5. Provide reproductive health training and informational conferences for contractors and other providers.				X
6. Support Women's Health activities including the promotion of the importance of preventive screening and check-ups.			X	X
7. Conduct ongoing review of population and program data to assess needs, identify disparities and develop effective strategies.				X
8.				
9.				
10.				

b. Current Activities

In FY 2011 state funding for FP clinical services was further reduced; however, there continue to be 37 provider sites on 6 islands.

Using supplemental/carryover Title X funding, FFP purchased contraceptives for FFP providers with an emphasis on LARC methods. It is anticipated a minimum of 450 low-income, uninsured and underinsured clients will benefit from these effective contraceptives in preventing unintended pregnancy. Thirty-three FFP sites across 3 counties were able to obtain additional contraceptive supplies including LARC methods. Client use overall of LARC methods increased from CY 2008 to CY 2011 from 4.5% to 7% with a slight decrease (1%) in oral contraceptives. There are now 52 clinicians trained in IUD insertion and 56 in Implanon insertion.

FFP is continuing to partner with the Domestic Violence Action Center to conduct healthcare IPV provider trainings statewide to recognize signs and symptoms of DV and help clients develop safety plans. To date trainings reached 313 providers including FFP providers, dentists, and outreach workers. Evaluation shows providers will use information in improving screening and intervention services.

The FPP completed a request for proposal for 2013 to provide FP health education. Fourteen health educators will focus on direct contacts, reaching high risk populations and increasing knowledge on where to access family planning services if needed.

c. Plan for the Coming Year

The annual performance objectives were changed to reflect a 5 percent improvement from the 2010 annual indicator (the latest available data).

Since 2009 when the current contract period began there has been a restriction of total State funding in the FPP program of \$274,882 and Title X federal funding of \$30,879. New contracts are anticipated to begin January 1, 2013. If these funds are not reinstated there could be an adverse impact to service delivery. The FPP will continue to monitor contracts, offer training and technical support to contract providers who continue to serve high risk populations to obtain reproductive health information and access effective contraception.

Merck Pharmaceuticals provided a Nexplanon hormonal implant training prior to the 2012 Family Planning and Reproductive Health Conference. The 2012 conference included a presentation on unintended pregnancy data as well as other reproductive health data and practice information. With possible changes in the Title X program, there may not be funds to support a Family Planning and Reproductive Health Conference in 2013.

Using Title X funding, the Kalihi Palama Health Center will have translated 700 birth control DVDs in Chuukeese and Marshallese for women to take home and discuss this information with partners and/or significant others. The information will also be shared with other statewide family planning providers.

The FP HE will continue to collaborate with agency and community groups to expand educational efforts on reproductive health, risky sexual behavior, benefits of abstinence and delaying sex, contraception, and consistent condom use to prevent STDs.

The MCHB Women's Health Section continues to review State and program women's health to assess factors impacting specific groups for unintended pregnancy and contraceptive use, unique cultural beliefs, and to plan for interventions to address these needs.

State Performance Measure 2: *Percent of women who report use of alcohol during pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	4.2	4.1	4.1	4	4
Annual Indicator	6.0	6.3	6.7	7.2	7.2
Numerator	1107	1167	1230	1328	1328
Denominator	18342	18459	18374	18461	18461
Data Source		Hawaii State Department of Health			

Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	6	6	6	6	6

Notes - 2011

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.

Notes - 2010

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 2009 is the latest available data and was carried forward to 2010.

Notes - 2009

Data for this measure comes from the Pregnancy Risk Assessment Monitoring System (PRAMS). Data for the year 2008 is the latest available data, and was carried forward to 2009.

a. Last Year's Accomplishments

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 2010 indicator is 7.2% (the latest available data). The rate has stayed relatively stable over the past 5 years. The State objective and the Healthy People 2020 objective of 1.7% were not met.

Title V administers the Perinatal Support Services (PSS) Program with contracted providers throughout the State. The PSS providers conduct outreach, risk assessment/screenings, health education, case management to high-risk pregnant women, up to six months post-partum. Providers screen clients for alcohol prenatally and post-partum and provide brief interventions and referrals for treatment.

Title V also administers the Perinatal Support Services and Triage (PSST) program which provides comprehensive services to pregnant women who are identified with substance use, including alcohol, and establishes a triage and referral system. With budget restrictions, only the Waikiki Health Center-PATH Clinic and the Waianae Coast Comprehensive Health Center (WCCHC) currently provide services.

The federally funded Healthy Start Big Island Perinatal Health Disparities program (BIPHDP) provides perinatal and postpartum support services to high-risk pregnant women. The program targets women of Native Hawaiian, Other Pacific Islander, Filipino, Hispanic ancestry as well as adolescents. The program screens clients for alcohol prenatally and post-partum and provides 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.

In 2007 Children's Research Triangle (CRT) began working with Hawaii island perinatal stakeholders to develop a universal screening and intervention system for substance use in pregnancy. This includes use of the CRT 4P's Plus screening tool. A plan of action was developed to establish a screening, assessment, referral, and treatment (SART) system of care

for pregnant women who use alcohol, tobacco, or illicit drugs. Since 2008, the BIPHDP has screened women using the 4P's screening tool to identify clients with substance use. CRT screened 3,153 women from 2007- 2011. Of those screened, approximately 33% were drinking alcohol; overall, 49% had positive screens for some kind of substance use.

Title V Fetal Alcohol Spectrum Disorders (FASD) coordinator works closely with a State FASD Task Force comprised of private/public partners to build a system of services to prevent FASD. Activities include increasing awareness through educational outreach/dissemination of information, supporting legislation such as having warning signage about the dangers of alcohol consumption during pregnancy, supporting community based perinatal screening, promoting evidence based practices, and utilizing national FASD resources to train medical and health service providers on the importance of screening women of reproductive age for alcohol use and identifying/diagnosing children with FASD.

In January 2011 Great Lakes FASD Regional Training Center (FRTC) completed trainings at 3 sites on Oahu. Video conferencing of the training was offered to the neighbor islands targeted toward medical and allied health professionals and students. A proclamation signing was held with the Governor during the September FASD International Awareness Month.

The Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii provides system building support to improve statewide perinatal services and also coordinates the statewide Perinatal Advocacy Network (PAN) meetings. HMHB works with MCHB to support quarterly Perinatal provider meetings. HMHB also provides health messaging through an information phoneline, website and "Text4Baby" program. HMHB was awarded a federal Healthy Care grant in November 2010. The grant objectives are to promote awareness of available resources to expectant parents. Activities include dissemination of messages through social media and outreach.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct the Pregnancy Risk Assessment Survey to collect, analyze and disseminate data on alcohol use during pregnancy.				X
2. Execute and administer contracts for perinatal support services to provide outreach and risk assessments to pregnant women.	X	X		X
3. Provide Big Island Perinatal Health Disparities Project grant services for target groups through outreach and support services during pregnancy and 2 year interconception period including addressing risk factors for alcohol and other substances.	X	X		X
4. Execute and administer contracts to enhance the statewide perinatal system of care through assessment and advocacy; pregnancy resource, referral and information (phone line, website); and, perinatal support provider education and training.				X
5. Build comprehensive screening, assessment, referral, and treatment (SART) systems of care for pregnant women who use alcohol, tobacco, or illicit drugs on Hawaii and Oahu islands with Children's Research Triangle				X
6. Provide screening and referral for WIC low income perinatal clients who use substances.		X		
7. Develop a comprehensive system of care to prevent, identify and treat FASD as directed by the statewide FASD task force and coordinator.				X
8. Coordinate a Prenatal Health Issues Summit with				X

stakeholders on the island of Hawaii to improve the system of services and improve birth outcomes.				
9. Provide training on Fetal Alcohol Spectrum Disorders (FASD) prevention for medical, allied health professionals, and health care providers.				X
10.				

b. Current Activities

Title V perinatal programs continue as described. HMHB launched a marketing campaign to publicize resources to support healthy pregnancies and early newborn care. Title V MCHB will host a Prenatal Health Issues Summit with the stakeholders on the island of Hawaii to address critical service system issues to promote healthy births.

In October 2011, SAMHSA hosted a FASD conference for Native Hawaiian leaders in Hawaii. The conference generated greater awareness and involvement in the community. As a result there has been greater collaboration with the Hawaiian community in the FASD Task Force (TF).

TF priorities were revised this year to: data surveillance; education/training, prevention and awareness; and improving outcomes for screening of women and children. Logic models were developed for each priority area. A poster presentation on the Challenges of Building a Comprehensive FASD System was presented at a national research conference by TF member and University professor, Jane Onoye, in June 2012.

Dan Dubovsky, SAMHSA FASD Specialist, conducted a series of FASD trainings in June 2012. Participants included Ob-Gyns, pediatric residents, Department of Education staff, substance use counselors, and Child Welfare Services staff. FRTC also provided FASD prevention training in January. The SAMHSA training is focused on identification and behavioral intervention for children with FASD, while the CDC funded FRTC trainings focus on prevention of alcohol use during pregnancy.

c. Plan for the Coming Year

The data will be updated in next year's report. Objectives will be to reflect a 5% improvement from the 2010 indicator. The PSS programs, Healthy Start BIPHDP, WIC, and PSST services will continue.

A three month follow-up meeting to the Hawaii Island Prenatal Health Action Summit is planned to provide support and assure action plan activities are implemented to improve perinatal services on the Big Island. The state Office of Rural Health is supporting the Prenatal Summit as a key partner.

DOH programs, including Title V, have been identified as key partners in a CRT project to expand its Big Island substance use screening program on Hawaii island to Oahu and develop a comprehensive system of care for pregnant women who use alcohol, tobacco, or illicit drugs. CRT received a Hawaii Community Foundation grant to integrate its program at 6 federally qualified community health centers. Title V staff will participate in a September 2012 Leadership Institute to discuss substance use services for pregnant women.

HMHB will continue to conduct needs assessments to identify statewide PNC needs; coordinate PSS provider education and meetings; conduct statewide Perinatal Advocacy Network meetings to facilitate coordination and initiatives to improve perinatal care, including legislation; and manage its pregnancy resource referral and information, phone line, website, and facebook page. HMHB will continue to promote the Text4Baby free health messaging service.

The FASD TF activities will include sponsoring SAMHSA and FRTC training of trainers and integrating FASD curriculum/training into the medical and allied medical schools. The TF will

assess and evaluate current capacity to provide alcohol use prevention services by agencies/professionals including screening, brief intervention, and referrals. The TF will also collaborate with the Legislative Women's Caucus who have expressed interest in supporting legislation in 2013 to promote prevention of FASD. The TF is also exploring a partnership with the university marketing department to develop media resources.

Title V initiatives will focus on promoting evidence-based screening practices and tools for the perinatal, family planning and WIC contracted service providers, and pilot surveillance systems in selected agencies for screening and identification of prenatal alcohol use.

PRAMS surveillance will continue and publications updated to increase awareness of issues impacting pregnant women including prenatal alcohol use.

State Performance Measure 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.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					29
Annual Indicator		27.2	27.2	27.2	27.2
Numerator					
Denominator					
Data Source		NSCH Survey	NSCH Survey	NSCH Survey	NSCH Survey
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	29	29	29	29	29

Notes - 2011

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.

Notes - 2010

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.

a. Last Year's Accomplishments

This measure reflects the State priority to increase early child developmental screening. The 2007 national 2011 survey data for Hawaii compares favorably to the U.S. (27.2 vs. 26.4).

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

Hawaii's Title V Developmental Screening Group worked with partners to develop a fact sheet, logic model, environmental scan, and problem map which has been shared with others. In June 2011, the Screening Group presented its fact sheet to Hawaii's Keiki Caucus, consisting of legislators who focus on addressing children's issues, receiving favorable comments from

members. The Group works to ensure development screening is integrated into all Title V programs including the Primary Care Office contracts for the uninsured.

The Centers for Disease Control (CDC) collaborates with partners on a public awareness campaign, "Learn the Signs, Act Early." The campaign aims to educate parents and providers about child development including early warning signs of autism and other developmental delays and encourages developmental screening. CDC provides funds for a CDC Ambassador to support efforts to educate parents and providers about the importance of early intervention. Hawaii's CDC Ambassador works collaboratively with the Title V Screening Group.

Since 2009, the Oahu Chapter of United Way, Aloha United Way, adopted an early childhood initiative focusing on developmental screening of 3-4 year olds. In 2009, AUW through its grantee, Learning Disabilities Association of Hawaii, screened over 600 children on Oahu's Leeward Coast, a rural community with a large Native Hawaiian population. In 2010, this number increased as the effort expanded to the Kalihi-Palama area, a largely low-income, urban community with a diverse immigrant population. The grantee for the Kalihi-Palama area is PACT, one of Hawaii's leading non-profit family service agencies. PACT provides screening using ASQ, ASQ-SE tools, Otoacoustic Emissions Technology (hearing), 3DLEA Symbol puzzle and flip chart by Good-Lite (vision). Over 500 children have been screened.

The State's Early Learning Council (created in statute to develop an early learning system for children 0-5), released its Framework for a Comprehensive Early Childhood System which includes a health component as one of 4 pillars. One of the strategies is expanding efforts statewide to increase the number of children screened for developmental, behavioral, vision and hearing prior to kindergarten entry. The ELC represents 14 public and private entities including the Departments of Education, Health, and Human Services. The Framework serves as a key policy guide for agency action and coordination.

In August 2010, the federal DOE released its grant in partnership with the Department of Health and Human Services, Race to the Top-Early Learning Challenge. Hawaii submitted an application and included "Ensuring Developmental Screening is available statewide" as one of the goals for its quality plan for health. Although Hawaii was not a recipient of this grant, the Governor's Coordinator for Early Childhood is committed to using this application as a plan for the state. Thus, developmental screening remains a priority for the State early childhood plan.

The Fetal Alcohol Spectrum Disorder (FASD) Task Force works to improve screening and training activities. Trainings were conducted on Oahu and Maui to early interventionists and school personnel.

Ho'opa'a Project--Hawaii Autism Spectrum Disorders (ASD) State Implementation Grant is a collaborative project of the Hawaii Pediatric Association Research and Education Foundation with Family to Family Health Information Center, Family Voices, DOH/Children with Special Health Needs Branch, American Academy of Pediatrics (AAP)-Hawaii Chapter, and UH Department of Pediatrics/MCH LEND (Leadership Education in Neurodevelopmental and Related Disabilities). A project goal is to strengthen the medical home role to identify and coordinate services for children and youth with ASD and other developmental disabilities. The Project helped plan the AAP-Hawaii's conference "A Physician's Response to Autism" in April 2011 for 128 health care providers, allied health providers, teachers, and family members. A session on Screening Tools for Primary Care Providers included training on the Modified Checklist for Autism in Toddlers (M-CHAT) screening tool and the Project's referral/follow-up protocol.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor/track changes of eligibility at Early Identification Section and ensure families have ways to support children who		X		X

do not qualify for services to address developmental delays.				
2. Work with Early Head Start and Head Start and Head Start Collaboration Office to promote the Head Start model of screening.	X			
3. Convene stakeholders to promote screening in the context of a medical home (Head Start, Aloha United Way, Medicaid, Dept. of Education, AAP, etc.)				X
4. Promote use of the M-CHAT as a screening tool for autism through the federal MCH Bureau Ho'opa'a Project grant.	X			X
5. Integrate developmental screening protocols, information into Title V MCH programs and service contracts where appropriate.				X
6. Continue partnership with the American Academy of Pediatrics (AAP)-Hawai'i Chapter which promotes surveillance and screening within a medical home.				X
7. Integrate development screening as a priority health issue into State Plans and policy documents.				X
8. FASD Task Force continues to build the system for screening and identification of children with FASD.				X
9. Newborn Hearing Screening Program continues to monitor and screen infants and toddlers (0-3) for hearing loss.				
10. Establish and maintain partnerships with DHS CWS to promote a model of developmental screening for young children at high, moderate and low risk for abuse and neglect.			X	X

b. Current Activities

Hawaii is monitoring the number of children screened and referred for developmental delays related to eligibility for Early Intervention Services (EIS). EIS service providers have been instructed to ensure that parents are informed of their child's test results and are provided ways to support their children if they do not qualify for EIS.

Hawaii's Ho'opa'a Project ASD grant continues to advocate and educate on ASD. Ho'opa'a hosted an ASD Summit in December 2011.

The Title V Screening Group, in partnership with the Hawaii Head Start Collaboration Office and the Hawaii Association for the Education of Young Children, convened a Screening Conference in February 2012 for over 100 participants representing various early childhood agencies. Training was also provided statewide to practitioners working on "Parent Coaching" to help improve support for parents who may have children with a delay.

At the annual Title V Division meeting, a breakout session on Screening reviewed the National Survey of Children's Health data on screening and examined the limited findings based on gender and poverty levels.

The Title V Home Visiting program, Healthy Start (HS) provides services for children at 2 sites where children are screened for developmental delay using the ASQ and ASQ-SE. HS tracks children who are suspected of having a developmental delay and follows-up with appropriate referrals. With increased funding, the program has been able to expand to two additional sites on Kauai and Maui.

c. Plan for the Coming Year

Data will be updated when available. Hawaii will continue to monitor the number of children screened and referred for developmental delays related to eligibility for EIS. Parents will continue to be informed of their child's test results and provided ways to support their children if they do not qualify for EIS services.

The Newborn Hearing Screening program will continue screening newborns before hospital discharge.

The Title V Screening Group will continue to meet with partners to use data and information on current screening activities to improve the screening system (identification, referral, intervention and treatment) in Hawaii. The Group will also continue to develop protocols, referral sheets, and ancillary materials for the screening system and ensure developmental screening is integrated into Title V programs.

The Governor's Office sponsored "Collective Impact" process convenes public-private partners to address key social issues for the homelessness, elderly, at-risk and foster youth, working poor, and early childhood. In 2011, the Early Childhood (EC) Group chose to focus on developmental screening in partnership with the DOH. The Title V Screening Group is using the opportunity to expand partnerships to address this issue and to advocate for funding and legislation. Partners include the Department of Education which has expressed an interest in receiving results of the screens to appropriately prepare schools for children entering kindergarten; Department of Human Services (DHS) Med-QUEST Division, Hawaii's Medicaid agency, which administers the EPSDT program; and DHS Child Care Administration which is piloting the Early Childhood Pre-K Health Record Supplement which asks for information about developmental screens. The Collective Impact EC Group will select 2 communities to pilot an intervention to study outcomes and develop a learning collaborative.

With funding from the Maternal and Infant Early Childhood Home Visiting (MIECHV) grant, the Title V Home Visiting (HV) program is able to develop and support a network of home visiting programs statewide. This will allow the HV program to provide training and information across home visiting programs on a number of topics including the ASQ screening tool.

Hawaii's FASD Task Force meets regularly to address the needs identified in its 2004 survey of community providers and the general public. The Task Force is currently convening partners to develop a screening protocol for children in the Child Welfare System.

Ho'opa'a Project has updated its "A Medical Home Guide to Resources for CSHCN & Their Families" and is providing training to professionals and families. The Project plans to continue activities including training on ASD screening and referral; addressing insurance issues; expanding Family to Family Health Information Center with specialized ASD support; host ASD conferences and continue public awareness initiatives.

State Performance Measure 5: *Rate of confirmed child abuse/neglect reports per 1,000 for children aged 0 to 5 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					7.5
Annual Indicator		8	9.7	7	7
Numerator					
Denominator					
Data Source		University of Hawaii; Center			

		on the Family	on the Family	on the Family	on the Family
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	6.5	6.5	6.5	6.5	6.5

Notes - 2011

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.

Notes - 2010

Received updated data for 2009 and 2010.

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 2008. Data for 2009 and 2010 was not available at time of this report so data from 2008 was carried to 2009 and 2010.

a. Last Year's Accomplishments

This measure reflects the state priority to reduce child abuse and neglect (CAN). In 2010, the Hawaii CAN rate was 7.0 per 1,000 children 0-17 years of age (the latest available data). The state objective was not met. Comparatively Hawaii's CAN rate is better than the U.S. In 2009 for all children, the national rate of confirmed CAN reports was 10.1 (per 1,000 children, aged 0-17 years) compared to 7.2 for Hawaii.

For many years, Hawaii's families have benefited from statewide family support programs that help prevent incidents of CAN. The economic recession resulted in major cutbacks to services while family needs increased. CAN was selected as a State priority largely due to the major funding cuts to human service agencies, particularly the statewide home visitation (HV) program, Healthy Start (HS). HS had both a universal hospital screening program for at-risk families and voluntary HV services statewide. The screening program was eliminated in 2009 and only 2 HS sites remained.

In DOH, the Title V Maternal & Child Health Branch (MCHB) is state lead for primary and secondary CAN prevention. MCHB administers family strengthening contracts for parenting and child development services statewide for a telephone warm-line for parents, care givers, and service providers; the dissemination of written information on child development including community resources; short term in-home parenting support; and parent-child interactive parenting education groups for homeless families.

MCHB also administers the federal Community Based Child Abuse and Prevention (CBCAP) grant and serves as the lead agency for the public sector for the Hawai'i Children's Trust Fund (HCTF). Established in 1993 by Hawai'i Revised Statute SS350B as a public-private partnership to support family strengthening programs aimed at preventing CAN, and to increase funding for prevention through grants, tax check-off contributions and private donations, the HCTF is

comprised of an advisory board (AB), advisory committee (AC), and a coalition of members committed to the strengthening of families to prevent CAN. The Director of Health serves on the HCTF advisory board, MCHB serves on the AC, and MCHB staff provides support and direction to the AC and coalition.

The HCTF in partnership with the Joyful Heart Foundation released research on the perceptions of child abuse and neglect in Hawaii which served as the foundation for the planning and implementation of a statewide public awareness campaign, One Strong Ohana (OSO). Using a positive, strength-based approach, this statewide initiative's goal is to increase awareness that child abuse and neglect is preventable and that individuals can make a difference.

MCHB also participates in the Department of Human Services (DHS) Child and Family Service Review (CFSR)/Program Improvement Plan (PIP) planning and workgroups. Many of these PIP workgroups cover ongoing public health issues being addressed by MCHB including domestic violence, sexual violence, and family strengthening. DHS's array of services assessed and addressed the needs of children and families through child welfare caseworkers, the use of POS contracts, coordination with other State departments, and partnerships with community-based agencies. Services include the delivery of Title IVB2 Promoting Safe and Stable Families (PSSF) services through Family Preservation and Family Support.

MCHB contracts with Prevent Child Abuse Hawaii (PCAH) to facilitate the Child Abuse Prevention Planning (CAPP) Council in its work to develop: 1) year-round public awareness (PA) events and planning such as Child Abuse Prevention Month events; 2) advocacy and community building; and 3) education and training. Council members meet monthly and represent a broad spectrum of family strengthening and prevention organizations including public and private agencies and the armed services. The CAPP Council promotes the use of the protective factors in CAN prevention activities. The CAPP Council undertook a series of strategic planning sessions to identify and focus on the activities and efforts that would have the greatest impact on CAN prevention statewide including the evaluation and measurement of the impact of these activities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Executes and administers contracts to provide home-visiting services to families at risk for child abuse and neglect.		X	X	X
2. Executes and administers family strengthening contracts for services to families at-risk for child abuse and neglect, a telephone warm-line for parents, and services to homeless families.		X	X	X
3. Administers Children's Trust Fund to assure a system of community-based family support/strengthening services and promote adoption of protective factors for healthy child development.	X	X	X	X
4. Improves coordination/integration between Department of Health MCH Branch violence prevention programs including child abuse, domestic violence, sex assault, rape and bullying prevention.		X		X
5. Participates on community coalitions and councils dedicated to child abuse and neglect prevention, safety, and child and family well being.				X
6. Maintains partnerships with DHS CWS to support CAN prevention especially with regard to family strengthening programs.				X
7. Develops the network of home visiting providers to support	X			X

child development and prevent CAN as an intervention and system model.				
8. Increases the knowledge and involvement of the general public in CAN prevention efforts, (One Strong Ohana PA statewide campaign and statewide CAN prevention plan).	X	X	X	X
9.				
10.				

b. Current Activities

The Affordable Care Act (ACA) through the Maternal Infant Early Childhood Home Visitation (MIECHV) grant provided continued funding for 2 ongoing home visiting (HV) sites and for the restoration of the hospital based early identification (EI) component of the HV system. Funds also restored HV sites on two additional neighbor islands, bringing these services to rural communities. The Hawaii Home Visiting Network (HHVN) was established with membership and partnerships of evidence-based early childhood programs including Early Head Start, PAT, HIPPPY, as well as a culturally based HV model. Plans for the continued development of the HHVN will support referrals from the hospital based EI program.

The Governor appointed a new Early Childhood Systems Coordinator. This cabinet level position will develop a state structure that supports the Governor's early childhood plan and is part of the Governor's "New Day" in Hawaii initiative. Part of this plan includes the establishment of the Early Learning Advisory Board which will include a member of the HHVN.

The HCTF AC added a DHS-Child Welfare Services representative whose participation has strengthened collaborative CAN planning efforts. The HCTF OSO PA campaign was launched with the release of television and radio PSAs, print ads, and social media that featured resources for service providers and community members. MCHB is supporting the HCTF's efforts to expand the OSO campaign through its coalition members and corporate sponsors.

c. Plan for the Coming Year

Data will be updated in next year's report. The objective for the years 2012 to 2016 was changed to reflect a 5% improvement from the 2011 annual indicator.

As the Hawaii Home Visiting Network grows with increased membership, the state's capacity to respond to the home visiting needs of identified at risk families will expand. The MIECHV funding will also provide a mechanism for the state to demonstrate efficacy through the required benchmarks that must be addressed through this grant.

MCHB is working to improve the community's understanding of the relationship between violence prevention (CAN, domestic violence, sex assault, rape prevention) and its impact on children. Through a contract with the University of Hawaii, Department of Sociology, MCHB will use a community-based participatory approach to lead a process that builds the capacity of community leaders to address violence in their community; to promote and increase the public awareness of the importance of strengths based approaches to address risk factors; and to assume a systems-wide approach to address CAN prevention for the children of Hawaii.

The participatory approach will be used to develop a CAN/Violence Prevention Plan that will include an analysis of: 1) an overview of the child abuse and neglect (CAN) problem in Hawaii, 2) a literature review and background on violence and its relationship to other issues--child abuse, childhood learning and development, crime, domestic and intimate partner violence (DV/IPV), poverty, lack of education and resources of women etc (e.g. the relationship of violence to equity and other health and social problems); 3) identification of communities at the highest risk for violence, 4) community meetings using the Community Based Participatory Approach; and 5) engagement of parents/caregivers/former recipients of services. This will include collaborating with HCTF, DHS-CWS, the CAPP Council, the domestic violence and sex assault prevention

coalitions, the Early Learning Advisory Board, and other community providers.

The HCTF in conjunction with the MCHB's community-based participatory approach will conduct a series of partnership meetings with state departments, private agencies, parents, and community representatives to set the direction for the HCTF and to prioritize funding for CAN prevention efforts statewide.

State Performance Measure 6: *Percent of teenagers in grades 6 to 8 attending public schools who report that harassment and bullying by other students is a problem at their school*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					60
Annual Indicator		67.8	63.3	63.3	59.1
Numerator					
Denominator					
Data Source		YRBS	YRBS	YRBS	YRBS
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	55	55	55	55	55

Notes - 2011

Data from the University of Hawaii; Curriculum Research and Development Group; Hawai'i Youth Behavior Risk Survey (YRBS). YRBS is administered in odd-number years in the public middle schools and high schools. The annual performance objective for the years 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011 annual indicator.

Notes - 2010

Data from the University of Hawaii; Curriculum Research and Development Group; Hawai'i Youth Behavior Risk Survey (YRBS). YRBS is administered in odd-number years in the public middle schools and high schools. Indicator data from 2009 was carried to 2010.

a. Last Year's Accomplishments

This measure reflects the State priority to prevent bullying behavior among youth with a focus on adolescents. The 2011 YRBS data indicates 59.1% of public middle school students reported harassment and bullying is a problem at their school. The rate has steadily improved since 2007.

Currently, in the Department of Health (DOH) bullying prevention is addressed by both the Title V Maternal Child Health Branch (MCHB) and the Injury Prevention and Control Section (IPCS). MCHB, through its Adolescent Health Coordinator, is responsible for developing plans and coordinate policies and systems of care for adolescents. MCHB nurses on the neighbor islands play an important role in coordinating the population-based educational outreach and infrastructure building activities for bullying prevention in their communities.

IPCS provides support for the state Prevent Suicide Hawaii Task Force (PSHTF). Since there is a close association between suicide and bullying, the PSHTF also addresses bullying prevention. MCHB is a member of the PSHTF and the newly formed Oahu Suicide Hawaii Task Force (OSHTF).

Advocacy efforts in the state have focused on urging the state Department of Education (DOE) to implement the recommendations developed by the 2007 Safe Schools-Community Advisory Committee (CAC) which identified detailed steps to reduce bullying and harassment in the state public school system. In 2011 legislation to require the DOE to implement the CAC

recommendations was introduced. Act 214 passed, but without key provisions of the bill because of DOE's opposing testimony.

The legislative Keiki (child in Hawaiian) Caucus hosted an informational hearing on bullying prevention in July 2011 featuring presentations from the Asian Pacific Islander Youth Violence Prevention Center (APIYVPC) and exemplary individual school programs.

In the wake of Act 214 passage and also in response to federal DOE requests for states to do more to address school bullying and cyberbullying, the DOE announced a new campaign to fight bullying and cyberbullying in schools. Plans included more training for educators, better efforts to identify and help kids who are bullied, and increased outreach to stop bullying before it starts. Advocates will monitor progress of the announced initiative.

In early 2011, the AG's office released the Circle of Respect 2011 Crime Prevention Month Kit, a product of the National Crime Prevention Council. MCHB assisted with distribution of the calendar to youth workers and adults to use the tear out fact sheets to facilitate discussions on encouraging respect, safe social networking, and teen dating violence.

The Mental Health America of Hawaii (MHAH) has begun educational efforts on bullying and suicide prevention through trainings and hosting informational forums for youth, parents, teachers, providers, and community members. The APIYVPC and Farrington High School's counselors, located in an urban low-income community, also created a bullying training for young adults.

APIYVPC did not receive additional CDC funding to sustain the youth violence center. However, they continue to support use of a Safe Schools and Communities curriculum developed in partnership with the Waimanalo and Kailua communities, conduct research on youth violence issues, and provide presentations/training on bullying/youth violence prevention.

The Title V Bullying Prevention Workgroup continues to maintain a listing of the community level bullying prevention initiatives around the state. The Hawaii Island Anti-Bullying Coalition (HIABC) supports schools implementing the evidence-based Olweus Bullying Prevention Program (OBPP). Currently, 6 elementary schools have been trained and implemented the curriculum.

Other community based efforts include training and educational presentations on bullying prevention conducted by the Title V Maui MCHB nurse. An article was written for the local newspaper; presentations conducted for with the Community Children's Council, DOE principals, and family service providers; and a radio talk show appearance conducted. The Maui County Police Department (MCPD), Juvenile Services Section also provides education to the community about bullying prevention.

The Kauai Domestic Violence Task Force (KDVTTF) has developed a bullying prevention subcommittee to promote bullying prevention as a component of early domestic violence prevention.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify resources and current status of programs and services statewide.				X
2. Identify and network with key stakeholders to develop and implement collaborative strategies.				X
3. Provide community education and awareness to promote training and education on bullying prevention strategies.			X	
4. Implement and support education for parents, teachers, and			X	

others who are in contact with adolescents to help them recognize and intervene in episodes of bullying.				
5. Support Department of Education implementation of bullying prevention rules, procedures, and programs to improve school safety.				X
6. Advocate for bullying prevention policies to create safer schools and communities.				X
7. Advocate for bullying prevention policies to create safer schools and communities.				X
8. Support new research/data analysis on bullying using the YRBS dataset.				X
9.				
10.				

b. Current Activities

The passage of Act 214 requires the Board of Education (BOE) to monitor the DOE for compliance with administrative rules or statutes governing bullying, cyberbullying, and harassment and establish reporting requirements for the DOE. There were several legislative bills introduced in the 2012 legislative session sponsored by the Keiki Caucus to strengthen bullying prevention efforts in the schools; however, the bills failed to pass.

IPCS will continue to take the lead to assure the implementation of the 2007 DOE "Safe School" committee report recommendations and monitor DOE's compliance with Act 214. The ad hoc "Safe Schools" committee will continue to advocate for a stronger bullying prevention law in Hawaii.

The state Prevent Suicide Hawaii Task Force (PSHTF) have joined the efforts of mental health providers and have begun making presentations in the schools to the administrators, parents, teachers and students in efforts to prevent bullying at the school and community levels.

MCHB staff will continue to provide educational presentations that help prevent bullying and promote respect and tolerance for diversity. In 2011, MCHB worked with Kosraean leaders on Lanai to speak with students about developing relationships built on understanding and respecting differences in cultures.

The 2011 YRBS data was released in June resulting in a headline story in the State's daily newspaper highlighting the bullying and safety concerns in state public schools.

c. Plan for the Coming Year

The annual performance objective for the years 2012 to 2016 was changed to reflect a 5 percent improvement from the 2011 annual indicator.

Mental Health America Hawaii's (MHAH) and the state Prevent Suicide Hawaii Task Force (PSHTF) will continue work with schools and youth service providers to raise awareness about teen suicide and bullying by providing trainings in prevention strategies and intervention skills. MHAH is particularly committed to providing services to high risk youth such as Native Hawaiian and rural populations; lesbian, gay, bisexual and transgendered individuals; military families; and youth involved in the juvenile justice or foster care system.

Community and school based activities will continue including initiatives by local county police department juvenile services programs to integrate bullying prevention education into their community outreach efforts.

IPCS will continue to take the lead to assure the implementation of the 2007 DOE "Safe School" committee report recommendations and monitor DOE's compliance with Act 214. The ad hoc

"Safe Schools" committee will continue to advocate for a tougher bullying prevention law in Hawaii.

The Title V Bullying Prevention Workgroup continues to maintain a listing of the community level bullying prevention initiatives around the state. In December 2011, the Workgroup convened key DOH Title V and IPCS staff and community based partners to teleconference with bullying researchers from the University of Oklahoma and report on Hawaii prevention efforts especially culturally targeted initiatives.

The Title V CDC-assigned Epidemiologist and the APIYVPC staff have been conducting analysis of YRBS data to identify associations between bullying and other variables. Results of the research will be presented at the Global Health conference in October 2012 as an oral presentation. Associations between bullying with other forms of antisocial behavior, such as vandalism, shoplifting, skipping and dropping out of school, fighting, and substance use are explored. These findings may provide further benefit to bullying prevention efforts by finding associated health behaviors that may help to inform interventions and policymaking.

State Performance Measure 8: *Percentage of Hawaiian children, ages 2 to 5 years, receiving WIC services with a Body Mass Index¹ (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					
Annual Indicator			22.1	21.6	21.5
Numerator			3812	3851	3844
Denominator			17252	17827	17879
Data Source			PedNSS	PedNSS	PedNSS
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	19	19	19	19	19

Notes - 2011

The data appearing above is the same as National Performance Measure #14. The data for this new measure will be revised to reflect the new target population when it becomes available. See the Detail Sheet for SPM 8 for more information.

Footnote: Body Mass Index is defined as the ratio of weight in kilograms to the square of the height in meters.

Footnote: Childhood overweight is defined as a BMI at or above the 95th percentile for children of the same age and sex, based on the reference values included in the National Center for Health Statistics 2000 growth charts. The term "at risk for overweight" is applied to children whose BMI is between the 85th and 95th percentiles.

a. Last Year's Accomplishments

This measure reflects the State priority to reduce the rate obesity in young children ages 0-5 years. Hawaii has selected a new state performance measure. Adult and adolescent data in Hawaii has shown substantially increased estimates of obesity among Native Hawaiians compared to other groups. There are many factors that contribute to this disparity, but it is anticipated that this disparity starts early and will be seen in young children. The Title V program will use the race specific estimates from the WIC PedNSS data for the state measure. Key stakeholders, such as the state Office of Hawaiian Affairs, are interested in the data and will be important partners in future activities. Although data is not available for the 2011 report, the Title V CDC-assigned epidemiologist will work with WIC to generate this data for next year.

Healthy Hawaii Initiative (HHI) is the Department of Health (DOH) lead to promote healthy lifestyles using Tobacco Master Settlement funds. In conjunction with the Centers for Disease Control (CDC), HHI has developed a Physical Activity and Nutrition Plan and Supplement with strategies across the lifespan including young children. Due to reduced funding, the State Coordinator for Nutrition and Physical Activity Coalition (NPAC) position was eliminated. Maui and Kauai continue to operate NPAC to improve the health in areas of physical activity and nutrition. HHI received a grant to work on Breast Feeding Friendly Hospitals to encourage hospitals to promote breastfeeding and conducted an analysis of existing breastfeeding policies pertinent to Hawaii through state and federal laws.

To promote healthy weight for children, the WIC program developed a curriculum that focuses on 3 behaviors: physical activity, grocery shopping, and anytime vs. sometime foods. The curriculum uses motivational interviewing and stages of change to customize the discussion. In addition, families are offered a kit which includes a family guide and DVD that shows Sesame Street characters modeling healthy behaviors. Also, WIC purchased a locally developed children's book "Move 'Um" by the Head Start Program to promote physical activity for young children.

The Hawaii Initiative for Childhood Obesity Research and Education (HICORE) provides collaborative and multi-disciplinary leadership in research and education on childhood obesity, physical activity and nutrition. The Initiative is based at the University School of Medicine, Department of Pediatrics and is a collaborative effort of academic and community partners. HICORE worked with partners to develop and promote the public awareness campaign "Hawaii 5-2-1-0 Let's Go."

Hawaii's Children's Healthy Living Program for Remote Underserved Minority Population in the Pacific Region project (CHIL) has been working on a pilot to study data on preschool-aged children using Head Start programs across the state. Children and their parents use an accelerometer to measure physical activity, physical activity logs kept by parents on their children's activities. This data will identify methods to best measure children's activity in the next phase of the study. Community meetings were held on 3 islands to discuss community health topics to develop strategies to meet community needs.

The DOH Obesity Prevention Workgroup has been meeting to address the childhood obesity issue since it was identified as a state Title V priority. The workgroup is the DOH lead for early childhood obesity prevention efforts and works in partnership with the HHI. Members of this workgroup include representatives from WIC, neighbor island District Health Offices, and Family Health Services Division. A fact sheet, logic model, environmental scan and logic model were products of this workgroup.

The counties of Maui and Kauai were recipients of the CDC Communities Putting Prevention to Work (CPPW) grants. The grants overall goal was to reduce obesity through improved healthy activities and nutrition of all residents, including the hardest to reach and most at risk for diseases preventable by healthier lifestyles.

The Office of Head Start and Child Care promoted an evidence-based curricula for early childhood practitioners "I Am Moving I Am Learning," (IMIL) which focuses on physical activity and nutrition in child care settings. Hawaii Head Start staff is implementing this curriculum in their programs. Hawaii's Child Care Administrator working to develop this training statewide.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide education and support on appropriate dietary practices and physical activity.	X			

2. Access weight and height of children every 6 months at all WIC certifications.	X			
3. Provide information on dietary guidelines to professionals and the public.		X	X	
4. Promote healthy lifestyles through public education campaigns.			X	
5. Provide training for WIC/pediatric providers to improve weight related behaviors of families with young children.				X
6. Develop state capacity to analyze WIC data for the Pediatric Nutrition Surveillance System with a focus on ethnic/racial disparities.				X
7. Promote greater partnership and collaboration among PAN, early childhood, and Native Hawaiian stakeholders.				X
8. Work with partners to implement the State Physical Activity and Nutrition (PAN) Plan and Supplement in areas concerning young children.				X
9. Support research on effective measures for child nutrition, physical activity and weight.				X
10. Advocate for policies that promote health community design and active transportation.				X

b. Current Activities

The Title V Obesity Prevention Workgroup has been meeting to address issues facing childhood obesity. With support from the Governor who recognized early childhood as a critical engagement point to address childhood obesity and diabetes prevention, legislation to support an Obesity Prevention Task Force and funding for early childhood obesity was introduced and supported this legislative session. No SSB tax legislation was proposed this year largely due to strong opposition from the beverage industry.

With support from the Kauai CPPW grants, Sugar Sweetened Beverages (SSB) commercials were broadcast statewide drawing attention to excessive sugars in soda.

Advocates of Complete Streets hosted Dr. Richard Jackson, University of California to speak on "Designing Healthy Communities" to promote environmental changes toward designing healthier communities. His visit was used to help support state and county legislation to adopt Complete Streets standards.

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 Workshop's "Healthy Habits for Life" kit and is exploring coordination with early child care centers to ensure a consistent message.

A University epidemiology intern with the Title V CDC-assigned Epidemiologist began in June to examine the data discrepancies between the CDC PedNSS and Hawaii WIC analysis for childhood obesity among 2-4 years served by WIC.

c. Plan for the Coming Year

With funding from the legislature and support for a task force, DOH will implement strategies outlined in the HHI NPAC and Supplement in areas focusing on early childhood. The Task Force will be addressing multi-factors that lead to obesity and will develop recommendations for policy by the next legislative session.

The Title V Workgroup will be overseeing funding for early childhood obesity prevention. Funding will be used to support existing work on breastfeeding promotion, training to early childhood

practitioners using the IMIL curriculum, and for data surveillance. The DHS Child Care Administration is piloting an Early Childhood Pre-K Health Record Supplement to provide appropriate information on the child's health, growth, and developmental status for entrance into licensed Pre-Kindergarten (Pre-K) program which includes an Infant and Toddler Child Care Center, Group Child Care Center, and Group Child Care Home. Although BMI is not included on this form (especially as Infants and Toddlers are not measured with BMI), DHS is willing to include this information on revisions to this form.

Hawaii WIC will begin promoting the new USDA FNS core nutrition messages and resources to motivate moms to offer whole grains, low-fat milk and fruits and vegetables as part of family meals and snacks. WIC will continue to provide educational messages and resources to families on the importance of healthy weight for children.

The CDC, Division of Nutrition, Physical Activity and Obesity (DNPA) in conjunction with the Department of Health and Human Services, conducted regional trainings for states to review its "State Guide to Address Childhood Obesity in the Early Care and Education Setting." Hawaii participated via teleconference into the training to include key stakeholders in the discussion. Representatives from DOH, DHS Child Care Administration, Head Start Collaboration Office, and 2 Hawaii Head Start grantees, attended the training. It is expected that this group will continue to meet to address utilizing the CDC guidance.

The CHIL Project has selected 4 communities with large Native Hawaiian populations to measure physical activity, screen, and sleep time of 2-5 year old children: Nanakuli-Waianae, Waimanalo, Hilo, and Maui. Interventions at a community level will be measured in young children using accelerometers and parent journals. The Title V workgroup will partner with the project to study DOH programs which may be impacted by the study as well.

Honolulu and neighbor island counties have passed Complete Streets Ordinances. The DOH recognizes the importance of the Built Environment as a key obesity prevention strategy and supports advocacy efforts like these that promote healthy community design. DOH also partners with the Department of Transportation's Safe Routes to School to promote efforts to make walking and biking to school safer for young children.

State Performance Measure 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)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					
Annual Indicator			32.8	32.8	34.5
Numerator					
Denominator					
Data Source			National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	37	37	37	37	37

Notes - 2011

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.

a. Last Year's Accomplishments

This measure reflects the State priority to improve transition services to youth with special health care needs to adult health care. Hawaii has selected a new state performance measure using the National CSHCN survey that best reflects the current strategic focus of the Title V programs to improve transition to adult health care.

As a graduation requirement, all DOE public school students developed a personal plan to support their transition from school to post-secondary education/career. Students receiving special education are required to have an Individual Education Plan (IEP). For the 2009-2010 school year 76% of youth aged 16 and above had an IEP that included measurable postsecondary goals. The goal for school year 2010-2011 was 100%.

EPIC Ohana is contracted by the State Department of Human Services to administer the Youth Circles program for those aging out of foster care. This youth-driven, strength-based process helps foster care teens reach their transition goals. The Hawaii Youth Opportunities Initiative (HYOI) was formed to raise awareness of youth who "age out" of foster care & provides access to necessary supports for successful transition.

Family Programs Hawaii (FPH) provides services to prevent children from entering the foster care system, provides supports to children/families in the system, and assists foster youth with transitioning out of this system.

In 2010, Transition Aged Youth (TAY) Task Force was reconvened after the suicide of an 18 year old who had recently left the foster care system. Discussions centered around services for youth exiting foster care, particularly the loss of health insurance coverage when youth age-out. The Medicaid agency was aware of the problem and worked to streamline the transition process to adult health care coverage. A social worker from FPH chaired the TAY Task Force.

CSHNP continued its outreach services to medically eligible Supplemental Security Income (SSI) applicants less than 16 years of age. Assessment, information and referral, guidance to access services, and transition planning are provided as needed.

The Ho'opa'a Project-Autism Spectrum Disorders State Implementation Grant, a collaboration of Family Voices, CSHNB, American Academy of Pediatrics-Hawaii Chapter, and University of Hawaii/School of Medicine-Department of Pediatrics, was awarded to Hawaii by the federal MCH Bureau. Plans for an updated State/Community Resource Guide, "Rainbow Book," included a new chapter on Autism and updates for the Transition Planning chapter. The Guide was developed through an earlier MCH Bureau systems integration grant for CSHCN.

The Ho'opa'a Project presented a session on "Making the Transition to Adulthood for Patients with Autism Spectrum Disorders (ASD)" at the April 2011 American Academy of Pediatrics-Hawaii Chapter conference.

In February 2011, the Maui DOE, the Developmental Disability Council and other agencies, held

the third Big MAC (Moving Across Communities) Transition Fair for students in special education and their families. The Hilopa‘a Family to Family Health Information Center (HFFHIC) coordinator did a presentation on "Transition to Adult Life," and shared resources including a Transition Workbook and Personal Health Record. Over 20 local and state agencies (including the Title V CSHNP) hosted information booths. Given the success of the conference, Big MAC coordinators spoke at the statewide Pacific Rim Disabilities Conference in April 2011 to encourage other DOE districts to hold similar transition fairs.

CSHNP convened a Title V Transition Workgroup and incorporated transition planning into standard program practices with families. The Workgroup continues to network/education with other programs serving youth with special health care needs (YSHCN) on transition planning. Members met with the new Adult Congenital Heart Clinic staff to discuss transition planning and provide them with transition materials. The Workgroup developed a user-friendly "Footsteps to Transition" flyer for YSHCN and their families. The flyer was field-tested at informational events (Maui Big MAC and Special Olympics) and with CSHNP families.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate transition planning resource materials for Youth with Special Healthcare Needs (YSHCN) and their families including the Hilopa‘a Transition Workbook, Personal Health Record, and "Footsteps to Transition".				X
2. Continue to develop transition planning informational materials for consumers and service providers to assure transition planning support is provided to YSHCN and their families				X
3. Document, in the Rainbow Book Resource Guide, the best practices, protocols, and standards for coordinated care, including transition, between programs and agencies that serve children and youth with special health care needs.				X
4. Provide training on the Rainbow Book Resource Guide which includes information on transition services, to physicians, health care providers, and agencies that serve YSHCN and their families.				X
5. Identify and implement best policies, practices, and standards on transitioning youth with special health care needs to adult health care in selected pediatric and family physician practices.		X		X
6. CSHNP incorporates transition planning into policy and procedures, and provides staff training to assure effective implementation.		X		X
7. Network and partner with agencies/programs that service YSHCN and their families to integrate transition planning to adult healthcare into their organizational practices/policies including the Department of Education.				X
8. Analyze/review existing data sources on transition planning and identify new data sources to identify needs, monitor progress and evaluate services.				X
9. Promote the importance of transition planning through community fairs, conferences, and at regular community and agency meetings.				X
10.				

b. Current Activities

HYOI is now in East Hawaii, so 45 youth can enroll in the "Opportunity Passport". Epic Ohana has a current listing of resources (education, training, housing, medical, etc) for transitioning foster youth. DHS revised procedures so youth will have greater support in accessing medical coverage as an adult.

The Hawaii Department of Labor and Industrial Relations Workforce Development Division (WDD) supports "One Stop Centers" with free assistance to apply for education, employment, and training opportunities.

The 4th annual Maui and first Kauai DOE Transition Fairs were held. Community groups shared information with special education youth and families. Title V staff worked in conjunction with the state Medicaid agency and the HFFHIC, to conduct health fairs in Ka'u, a rural Hawaii Island community, targeted to the large Micronesian/Marshallese population. Information was provided on transition. The West Hawaii Kardiatic Kids support group promotes transition for youth with cardiac conditions to adult health care. Their website offers critical information to facilitate transition.

The Ho'opa'a Project released the 2012 Rainbow Book Resource Guide, which includes a chapter on transition planning. Statewide trainings on the Guide are free. Monthly webinar trainings on the Guide have been integrated into a pilot Medical Home Project for primary care physicians sponsored by the State's largest health insurer. One webinar will be dedicated to transition services.

c. Plan for the Coming Year

DOE Special Education services will continue efforts toward meeting its 2011-2012 objective to have 100% of youth age 16 and older have an Individual Education Plan (IEP) that includes appropriate measurable postsecondary goals. The DOE has a project targeting middle and high school students to increase their self-advocacy and self-determination skills. The Children's Community Council (CCC) and school complex transition personnel are exploring the potential of conducting more island/district transition fairs. The CCC is a partnership of parents, school personnel, private providers and other community members that provides community-based planning and evaluation, provides support and training to parents of special needs children, identifies gaps in service delivery and offers possible solutions, and provides system advocacy to support and maintain the quality of services needed in the local community.

The Title V Transition Workgroup continues to identify strategies to increase collaboration and service integration among agencies to improve transition planning for YSHCN and their families. A new partner is the state youth correctional program that is interested in developing a mini-transition Resource Guide for youth exiting their facility. The Workgroup will continue to strengthen its partnerships with the DOE since it serves many of the YSHCN in the state public school system. Workgroup activities will also focus on reviewing existing transition data to improve assessment and evaluate progress to improve the availability of transition planning services for YSHCN and their families.

The Affordable Care Act allows young adults to stay on their parents' health care plan until age 26, by requiring health plans and issuers that offer coverage to children on their parents' plan to make the coverage available until the adult child reaches the age of 26. Health insurance coverage supports youth in their transition to adult health care.

CSHNP social workers and other professional staff will continue to provide outreach services and transition information to medically eligible SSI applicants.

Child and Adolescent Mental Health Division (CAMHD) will continue using the Coordinated Service Plan (CSP) to plan strategies that support the youth achieving his/her goals. The Mental Health Transformation Grant helped sponsor the Network of Care, an online resource for those

concerned with behavioral health, that can help people find services, interact with others, and store medical/service information that may be useful for transitioning youth.

E. Health Status Indicators

The series of Health Status Indicators (HSI) provides information and helps portray the health of a population. They can assist maternal child health (MCH) programs by directing public health efforts, guiding surveillance of important MCH indicators, and providing a measure of evaluation. The Department of Health monitors trends in many of the health status indicators to inform programs and some will be discussed below. The data is reported on forms 20 and 21.

LOW BIRTH WEIGHT

HSI #01A: The percent of live births weighing less than 2,500 grams

HSI #01B: The percent of live singleton births weighing less than 2,500 grams

Low birth weight (LBW), defined as <2500 grams, infants are more likely to experience long-term disability or die during the first year of life than normal weight infants. Approximately 2/3 of infants that die within the first year of life are of low birthweight. There are many factors associated with an increased risk of LBW and include race, age, personal history, poverty, maternal smoking, substance abuse, low education, and multiple gestation pregnancies. This percentage is influenced by multiple gestational pregnancies and assisted reproductive technologies that result in a shortened gestation and increased likelihood of LBW, and vary by race/ethnicity, income, and other factors. Further details of the current rate of multiple gestational pregnancies and their unique risks may help identify programs that could target the reduction of the overall rate of low birthweight.

The proportion of LBW birth has remained stable over the past 5 years with an estimated 8.2% of births in Hawaii in 2011 were considered to be of LBW. Hawaii remains above the Healthy People 2010 objective of 5.0% of all live births to be LBW. Similarly, the percentage of infants born in a singleton pregnancy has remained stable in Hawaii with 6.5% the proportion in 2011.

Current programs like statewide perinatal support services that target high risk women and women's health promotion programs will continue to impact this number to help decrease the risks of low birth weight in those groups who are particularly at risk for poor birth outcomes. This indicator must be carefully monitored to see if the current trends continue. Efforts to look at prematurity rates in addition to birth weight have been implemented due to recent legislation that focused on preventing non-medically indicated cesarean sections and inductions of labor prior to 37 weeks. A workgroup was convened in 2009 that included March of Dimes, Healthcare Association of Hawaii and Healthy Mothers Healthy Babies Coalition of Hawaii to address this resolution. An initial analysis using vital statistics demonstrated an increased rate of early inductions and cesarean without indications in 2005-2008, compared to 2001-2004. Results were shared with stakeholders. Physician and hospital surveys gathered information in order to develop recommendations for practices related to elective inductions and cesarean deliveries with a goal to reduce the preterm birth rate in Hawaii. Recommendations were made and continued activity related to prematurity reduction is ongoing including a recent State wide initiative aimed at reducing premature births.

CHILD DEATHS AND INJURIES:

HSI #03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

HSI #03B: The death rate per 100,000 from unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

Injuries are the leading cause of death in children after the first year of life. Deaths due to

unintentional injuries, specifically motor vehicle accidents is an important measure of children's health. Nonfatal injuries is another measure of the health of children as they cause a substantial burden on society due to emergency room visits, hospitalizations, and lifetime medical expenditures due to disabilities. Continued surveillance of both non-fatal and fatal events is important to inform activities geared towards preventing childhood injuries.

The death rate in children 14 years and under due to unintentional injury has remained stable over the past 5 years with a rate of 6.7 per 100,000 children 14 years and younger in 2011. The rate of deaths due to motor vehicle accidents has declined over the past 5 years with an estimated rate of 1.6 per 100,000 children 14 years and younger in 2011 compared to 2.7 in 2007.

HSI #04A: The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger.

HSI #04B: The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.

The number of nonfatal injuries in Hawaii has remained fairly stable with a rate of 219.6 per 100,000 children 14 years and younger in 2011. The rate of nonfatal injuries that involved motor vehicle crashes has declined over the past 5 years with a rate of 21.3 per 100,000 children 14 years and younger in 2011, compared to a rate of 40.0 in 2007.

Infrastructure building efforts have likely contributed to reducing the death and nonfatal injury rates. Effective analysis and dissemination of child mortality data by the DOH Injury Prevention and Control Program (IPCP) and more recently by the Child Death Review System have helped community advocates to develop policy and program strategies to reduce this rate. Advocacy groups like the Keiki (Child) Injury Prevention Coalition (KIPC) have been vital to assure passage of laws for child safety restraints, conduct public safety education, and promote enforcement efforts. Other programs addressing child injury described elsewhere in this report (NPM 10) have likely contributed to the rates in Hawaii.

CHILD POPULATION

HSI #06: Infants and children aged 0 through 24 years enumerated by sub-populations of age group, race, and ethnicity.

Demographically, about 29% of the population is under the age of 25 in Hawaii. This population is diverse and very multi-cultural. The classification of race/ethnicity is complex particularly in Hawaii due to limitations of available data sources and large proportion of the population that belong to more than one race group. This has impacts on the ability to tailor targeted interventions towards specific population groups. In addition to diversity related to race/ethnicity, efforts to incorporate other measures of health inequity are looked at in program planning. Some of these other measures are referred to as social determinants of health and include things such as poverty status, education, employment, health insurance, and geography.

Information on single race groups is available for children under the age of 25 come from the Hawaii Health Survey. Efforts were made to match the singly coded algorithm used to report birth certificate data which ignores the large proportion of people in Hawaii who report more than one race. For example, the 2010 census reports that 22.9% of all people are of more than one race group in Hawaii, with higher numbers for younger populations as shown by 41.3% of those under 18 years of age. This pattern is also reflected in the birth certificate data in Hawaii reported by the National Center for Health Statistics, based on 2003 data, which highlighted that 33.4% of mothers and 32.4% of fathers report more than one race among those who had a live birth.

The data available for children under 25 is singly coded into one race group and shows that a high proportion are Asian (43.1%) and Native Hawaiian or other Pacific Islander (40.5%), with smaller proportions being White (10.5%) or Black (1.8%). Hispanic or Latino ethnicity was

reported in quite a large proportion (16.3%) and was not recorded in 1.1% of all children 0 to 24 years of age. This Hispanic population may be related to those that report more than one race group and would include both newer immigrants and those that have been established in Hawaii for several generations.

HSI #7: Live births to women (of all ages) enumerated by maternal age, race and ethnicity. Estimates by race among live births comes from the birth certificate data and is only representative of a singly coded race group with Native Hawaiian or Other Pacific Islander (36.3%) and Asian (34.1%) representing more than 2/3 of births in the State. Those that are white account for nearly a quarter (23.8%) of births. Approximately, 16.1% of births were to those that reported Hispanic ethnicity.

HSI #8: Deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race and ethnicity.

Estimates by race among child deaths comes from the death certificate data and is only representative of a singly coded race group with Native Hawaiian or Other Pacific Islander (56.0%) and Asian (22.2%) representing more than 2/3 of child deaths in the State. Those that are white account for 16.2% of deaths. Approximately, 19.2% of deaths were to those that reported Hispanic ethnicity.

In addition to not being able to report more than one race group in the data sources available for estimates of children and live births, there may be some variation in coding of race groups between the birth certificate and the Hawaii Health Survey, particularly for White and Hispanic ethnicity so direct comparisons across the data sources are of limited benefit.

Programs that target young Native Hawaiian or Other Pacific Islanders and Hispanic or Latinos should be an important focus for public health programs due to their large representation of births in the State and their over-represented in child deaths. The large proportion of children and births in the Asian also represents an important population, which comprises several diverse Asian subgroups, for programs. For example, are there any protective factors found in some of the Asian subgroups that can be incorporated into program activities for all population groups. Finally, additional efforts to better clarify the impact of multiple race reporting in the State is needed. Efforts to report out multiple race in child deaths through the Child Death Review program are ongoing.

OTHER DEMOGRAPHIC DATA:

Some of the other demographic data reported in the HSI's include information on enrollment in various programs and other factors such as high school dropout. Data reported in this Title V report for these are done on an annual basis and dependent on the availability of various data sources so not all were updated with this report. Discussion below will briefly comment on some of the trends in these indicators when reviewed over time for the overall population and not related to variation by race or ethnic group.

HSI #9: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race and ethnicity

Over time there have been substantial increases in the number of children under 20 years of age served by the WIC program with an estimated 46,903 enrolled in 2011 compared to 41,985 in 2006.

The number of children served by the Medicaid program also continues to increase with an estimated 131,048 in 2010 compared to 119,622 in 2009.

The number of children enrolled in food stamp programs also continues to increase with 70,141 in 2011 compared to 51,114 in 2009.

The proportion of children living in single parent households has also steadily increased with 13.7% in 2009 (latest year data is available) compared to 7.3% in 2005.

The proportion of children who don't complete high school has decreased to 3.7% in 2011 compared to 5.2% in 2007.

Other data included in this report (HSCI 5a-d) show worse outcomes and utilization measures among those that are in Medicaid. Many of these children are likely to also be participating in food stamps and WIC programs due to similar eligibility requirements. Efforts to partner with Medicaid to improve outcomes among these populations continue to evolve and are an important area of concern for the Department. Some of the initiatives are described elsewhere, but partnering for data on early developmental screening, child oral health, and child obesity are some current examples. The generally increasing enrollment with these programs and our partnerships with providers such as community health centers can play a role to help improve outcomes for some of these populations.

F. Other Program Activities

GENETICS PROGRAM has been extensively involved in planning, coordinating, implementing, and evaluating statewide activities to improve access to genetic services and education. This includes developing genetics education to health care providers, public health staff, and students; maintaining newsletters and several websites; supporting Hawai'i Community Genetics; establishing Neighbor Island genetics services (including telemedicine clinics); working with the Newborn Metabolic Screening Program on current issues such as expansion of disorder panel, quality improvement activities, retention of blood spot, and emergency preparedness; and developing the Birth Defects Program. Grant activities have included:

- Western States Genetic Services Collaborative, a multi-state effort to increase the capacity of Alaska, California, Hawaii, Idaho, Oregon, Washington, and Guam genetics and newborn screening programs to perform their assessment, policy development, and assurance functions.
- Sickle Cell Disease Project to develop a standardized follow-up protocol and education about Sickle Cell Disease and Trait for the families with newborns detected via the newborn screening program.
- Newborn Screening Using Tandem Mass Spectrometry: Financial, Ethical, Legal, and Social Issues (FELSI), a multi-state collaboration to research, identify strategies and develop materials for addressing FELSI.
- Muscular Dystrophy Surveillance, Tracking, and Research Network, a multi-state collaboration to determine the incidence and outcomes of Duchenne and Becker muscular dystrophies.

The Genetics Program continues to work with Guam to develop a comprehensive newborn screening follow-up program.

/2012/ New grant activities: Newborn Screening Clearinghouse Challenge Grant Project to gather input from our diverse population and provide feedback for the development and improvement of the National Newborn Screening Clearinghouse website.//2012//

/2013/ The Sickle Cell project ended with completion of a new protocol for treatment and follow-up. Activities for the Tandem Mass Spectrometry project have been subsumed under the WSGSC including updates to the parent fact sheets and maintenance of the website. All other activities under the project are now completed.//2013//

HAWAII BIRTH DEFECTS PROGRAM (HBDP) is a population-based active surveillance system for birth defects and other adverse pregnancy outcomes that was established in 1988. It annually finds and collects demographic, diagnostic, and health risk information on 800 to 1,000 infants diagnosed with a birth defect. Data are analyzed for incidence, trends, and clustering, which contribute to the identification of genetic, environmental hazards, and other causes or risk factors. HBDP is funded from \$10 of each marriage license fee which goes into a special fund. HBDP was established as a DOH program by the 2002 State Legislature (H.R.S. SS321-421). As part

of the transition into the DOH, four HBDP civil service positions were established.

The State Early Childhood Comprehensive Systems grant is funded by the Maternal and Child Health Bureau (MCHB) in recognition of the fact that the early childhood systems building work of the federal, State, and local governments and private foundations over the last 15 years has been impressive, although, the proliferation of early childhood programs from diverse and unconnected service systems left significant gaps between the services that need to be addressed. ECCS is a systems' building grant that supports collaborative partnerships to align early childhood service systems priorities and integrating their funding streams in order to maximize health, mental health, early care and education, parenting education and family support benefits to the children, families, and communities served. Hawaii's ECCS grant continues to partner with state and federal agencies including the Housing and Urban Development (HUD), Departments of Education and Human Services, Aloha United Way, Blueprint for Change, Good Beginnings Alliance, Hawaii Association for the Education of Young Children, Head Start Association of Hawaii, Head Start State Collaboration Office, Kamehameha Schools, Medical Home Works!/Community Pediatrics Institute, University of Hawaii Center on the Family.

SAFE SLEEP HAWAII's goal is to reduce the numbers of deaths through an awareness campaign targeting parents, caregivers, and health care providers. This will be done through: existing programs serving young families, a public awareness campaign, and hospitals with birthing facilities. The committee has begun an outreach campaign using informational packets, PSA's, and educational sessions. Many agencies that service young families are represented on the Committee which functions as a sub-committee of the Keiki Injury Prevention Coalition. This Committee has not met for a time but is being re activated. The MCHB will participate on this committee as it is a natural extension of the efforts of the Child Death Review Initiative and involvement in childhood injury prevention efforts.

DOMESTIC VIOLENCE FATALITY REVIEW The Maternal and Child Health Branch has implemented a Domestic Violence Fatality Review which is a legislative initiative intended to reduce the incidence of preventable deaths related to domestic violence. The DOH is the lead agency to administer statewide team reviews and through this process the MCHB is collaborating with key agencies involved in Domestic Violence. The hope is that thru this collaboration the MCHB can participate in advocacy efforts improve the systems of care and interventions related to intimate partner violence.

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

G. Technical Assistance

Needs Assessment Issue Workgroup members were asked to evaluate trainings provided as part of the Title V needs assessment process and identify other training/technical assistance requests to support further needs assessment work. Because many of the program staff work primarily in the administration and management of specific programs or provide direct/enabling services to consumers, TA is being requested to improve knowledge and skills for systems building.

Also many of the needs assessment priority issue groups are identifying strategies focusing on the development of effective public health messages and understanding effective methods of communicating these messages to target audiences through social marketing and new media.

Other TA requests include support to develop logic models and improve use and interpretation of data. The last two requests will likely be addressed using existing staff resources within FHSD. ***//2013/ The Title V agency is requesting TA to conduct a training and/or presentation on the life course approach with Dr. Michael Lu, Director for the federal MCH Bureau. This will also assist with implementation of the State Systems Development Initiative grant to identify life course metrics. Consultation to discuss life course metrics is also requested. The life course information can also help support and inform the Governor's Early Childhood (EC) initiatives including the development on a EC state plan.***

Once the FHSD Reorganization proposal is approved later this year it will more accurately current functioning/resources of the Division after major workforce reductions and budget restrictions. FHSD would then like to begin strategic planning to outline areas to improve efficiency, accountability, and collaboration as well as identify key areas for rebuilding when public financing improves. TA is requested to assist with strategic planning for the Title V agency. An initial program planning training is underway using TA funds for the Children with Special Health Needs Program, however, FHSD would like to request TA to develop a strategic planning process for the entire Division and assist with implementation. //2013//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	2274139	1622293	2270185		2229698	
2. Unobligated Balance <i>(Line2, Form 2)</i>	499384	670205	475518		93332	
3. State Funds <i>(Line3, Form 2)</i>	21633241	21950067	23985044		23785948	
4. Local MCH Funds <i>(Line4, Form 2)</i>	0	0	0		0	
5. Other Funds <i>(Line5, Form 2)</i>	1697984	62674	75000		75000	
6. Program Income <i>(Line6, Form 2)</i>	11427833	10029986	10750224		11043354	
7. Subtotal	37532581	34335225	37555971		37227332	
8. Other Federal Funds <i>(Line10, Form 2)</i>	47452298	38210094	48814287		45736612	
9. Total <i>(Line11, Form 2)</i>	84984879	72545319	86370258		82963944	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	2585640	2648264	2887026		2837999	
b. Infants < 1 year old	2902244	1217838	1819399		1822929	
c. Children 1 to 22 years old	4871990	4017854	4526179		4732644	
d. Children with	18386012	17494049	19007935		18591721	

Special Healthcare Needs						
e. Others	7527118	7839351	8048532		8061741	
f. Administration	1259577	1117869	1266900		1180298	
g. SUBTOTAL	37532581	34335225	37555971		37227332	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	758500		796555		650000	
b. SSDI	93713		135803		78428	
c. CISS	0		0		0	
d. Abstinence Education	0		0		126243	
e. Healthy Start	1597605		2381832		933814	
f. EMSC	0		0		0	
g. WIC	36335708		36363544		32800987	
h. AIDS	0		0		0	
i. CDC	577258		572883		558445	
j. Education	4551250		4551250		2150294	
k. Home Visiting	0		0		4814174	
k. Other						
Other	0		4012420		3624227	
other	3538264		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	18783804	19642890	20001270		20084781	
II. Enabling Services	10384140	8152920	9542083		9414668	
III. Population-Based Services	1813754	1128529	1471518		1442152	
IV. Infrastructure Building Services	6550883	5410886	6541100		6285731	
V. Federal-State Title V Block Grant Partnership Total	37532581	34335225	37555971		37227332	

A. Expenditures

Significant Budget Variations -- Form 3 (Fiscal Year 2009)

The total Title V Block Grant amount awarded to the State in fiscal year 2009 was \$2,265,527. Out of the amount awarded, a sum of only \$1,451,417 was expended in federal fiscal year 2009 due to carryovers from fiscal year 2008. The actual expenditures of \$938,955 for the category "Unobligated Balance" was higher than the budgeted amount of \$497,888 used for the FY 2009 Title V application due to an under estimation of the unobligated balance.

The amount of funds actually expended under the category "State Funds" was \$4,999,004 less than the budgeted amount in fiscal year 2009. The decrease in expenditures was largely due to reductions for the Healthy Start Program. The Healthy Start Program received a \$3.5 million reduction in State fiscal year 2009. Other major reductions included cuts to operating subsidies

for community hospitals (\$302,000), and the family planning program (\$279,246).

The amount actually expended under the category "Program Income" was \$500,791 less than what was budgeted for under this category. The reason for the variance is that the budget ceiling for the Newborn Metabolic Screening Program was established at a higher level than what is currently being expended by the program. In addition, expenditures for the Birth Defects Monitoring Program were below budgeted estimates due to staff vacancies.

Significant Budget Variations -- Form 4 (Fiscal Year 2009)

The amount budgeted for the category "Infants < 1 year old" was \$10,414,628, and the actual amount expended was \$7,532,565, a difference of \$2,882,063. In addition, the amount budgeted for the category "Children 1 to 22 years old" was \$10,768,239, and the amount actually expended was \$8,860,444, a difference of \$1,907,795. The reason for the variances in these categories are primarily due to a \$3.5 million reduction for the Healthy Start Program in State fiscal year 2009.

Significant Budget Variations -- Form 5 (Fiscal Year 2009)

The budgeted amount for the category "Enabling Services" was \$20,364,978 in fiscal year 2009, and the amount actually expended under this category was \$17,547,582, a difference of \$2,817,396. This was mainly due to funding reductions for the Healthy Start Program.

The amount budgeted for the category "Population-Based Services" was \$3,727,704 in fiscal year 2009, whereas the actual amount expended under this category was \$3,016,527, a difference of \$711,177. This was due to funding reductions for the Healthy Start Program.

The budgeted amount for the category "Infrastructure Building Services" was \$9,798,118 in fiscal year 2009 and the amount actually expended under this category was \$8,236,355, a difference of \$1,561,763. The variance was due to funding reductions for the Healthy Start Program and vacancies in the Birth Defects Monitoring Program.

/2012/ Significant Budget Variations -- Form 3 (Fiscal Year 2010)

Item 1. Federal Allocation. The total Title V Block Grant amount awarded to the State in fiscal year 2010 was \$2,270,185. Out of the amount awarded, a sum of only \$1,598,544 was expended in federal fiscal year 2010 due to carryovers from fiscal year 2009.

Item 2. Unobligated Balance. The actual expenditures of \$594,736 for the category "Unobligated Balance" was higher than the budgeted amount of \$437,770 due to an under estimation of the unobligated balance.

Item 3. State Funds. The amount of funds actually expended under the category "State Funds" was \$2,393,157 less than the budgeted amount in fiscal year 2010. The decrease in expenditures was largely due to furlough savings (2 days per month--an approximate 9.77% salary reduction) starting in October 2009.

Item 5. Other Funds. The amount actually expended for the category "Other Funds" was \$797,849 less than what was budgeted in fiscal year 2010. This was primarily due to the elimination of \$463,587 in Temporary Assistance for Needy Families ("TANF") funds for the Family Planning Program and \$74,032 for the Teen Pregnancy Program.

Item 6. Program Income. The amount actually expended under the category "Program Income" was \$5,210,789 less than what was budgeted for under this category. The reason for the variance is that the budget ceiling for the Newborn Metabolic Screening Program was established at a higher level than what is currently being expended by the program. In addition, expenditures for the Birth Defects Monitoring Program were below budgeted estimates due to staff vacancies,

and \$3 million in Tobacco Settlement funds were eliminated for the Healthy Start Program.

Item. 8 Other Federal Funds. The amount actually expended for the category "Other Federal Funds" was \$4,243,035 more than what was budgeted for under this category. The primary reason for this is that the amount that was budgeted for the WIC grant in fiscal year 2010 was \$33,913,876, however additional grant funds were received, resulting in expenditures of \$36,608,242.

Significant Budget Variations -- Form 4 (Fiscal Year 2010)

Item I. b. Infants < 1 year old. The amount budgeted for the category "Infants < 1 year old" was \$5,038,892, and the actual amount expended was \$2,276,646, a difference of \$2,762,246. The primary reason for this reduction was the elimination of the Tobacco Settlement funds for the Healthy Start Program.

Item I. c. Children 1 to 22 years old. The amount budgeted for the category "Children 1 to 22 years old" was \$7,431,859, and the amount actually expended was \$4,852,380, a difference of \$2,579,479. The reason for the variance was primarily due to the elimination of Tobacco Settlement funds for the Healthy Start Program in State fiscal year 2010 and furlough savings.

Item I. d. Children with Special Healthcare Needs. For the category, "Children with Special Health Care Needs," the amount budgeted was \$20,116,336, and the actual amount expended was \$16,672,515, a difference of \$3,443,821. The variance is primarily due to a reduction in expenditures from the Early Intervention Special Fund due to: a) decreased reimbursements from Medicaid; b) reduced expenditures for the Birth Defects Monitoring Program due to staff vacancies; and c) furlough savings.

Item I. f. Administration. The budgeted amount for the category "Administration" was \$1,374,538, and the amount actually expended was \$1,223,353, a difference of \$152,185. This difference is primarily attributable to furlough savings in fiscal year 2010.

Significant Budget Variations -- Form 5 (Fiscal Year 2010)

Item II. Enabling Services. The budgeted amount for the category "Enabling Services" was \$13,668,945 in fiscal year 2010, and the amount actually expended under this category was \$9,419,096, a difference of \$4,249,849. This was mainly due to the elimination of Tobacco Settlement funds for the Healthy Start Program and reduced expenditures from the Early Intervention Special Fund due to decreased reimbursements from Medicaid.

Item III. Population-Based Services. The amount budgeted for the category "Population-Based Services" was \$2,827,811 in fiscal year 2010, whereas the actual amount expended under this category was \$1,545,601, a difference of \$1,282,210. This was primarily due to the elimination of Tobacco Settlement funds for the Healthy Start Program and a reduction in expenditures from the Early Intervention Special Fund due to decreased reimbursements from Medicaid.

Item IV. Infrastructure Building Services. The budgeted amount for the category "Infrastructure Building Services" was \$8,148,533 in fiscal year 2010 and the amount actually expended under this category was \$5,693,549, a difference of \$2,454,984. The variance is mainly due to the elimination of the Tobacco Settlement funds for the Healthy Start Program, elimination of TANF funds for the Family Planning Program, staffing vacancies for the Birth Defects Monitoring and Newborn Metabolic Screening Programs, and furlough savings.//2012//

/2013/SIGNIFICANT BUDGET VARIATIONS -- FORM 3 (FISCAL YEAR 2011)

Item 1. Federal Allocation. The total Title V Block Grant amount awarded to the State in fiscal year 2011 was \$2,250,730. Out of the amount awarded, a sum of only \$1,622,293 was

expended in federal fiscal year 2011 due to carryovers from fiscal year 2010.

Item 2. Unobligated Balance. The actual expenditures of \$670,205 for the category "Unobligated Balance" was higher than the budgeted amount of \$499,384 because the unobligated balance was underestimated.

Item 5. Other Funds. The amount actually expended for the category "Other Funds" was \$1,636,310 less than what was budgeted in fiscal year 2011. This was primarily due to the elimination of \$1,320,014 in Temporary Assistance to Needy Families ("TANF") funds for the Healthy Start Program; \$235,246 for the Full Inclusion Program; and \$67,738 for the Keiki Care Program. The only remaining funding source under this category is the Child Death Review Program.

Item 6. Program Income. The amount actually expended under the category "Program Income" was \$1,397,847 less than what was budgeted for under this category. This was primarily due to an overestimation of the budget ceiling for the Early Intervention Services Special Fund account. The planned budget was for the early intervention special fund was \$2,500,000, however the actual amount expended amounted to only \$573,734, a difference of \$1,926,266. This savings, however, was offset somewhat by an increase in expenditures from the Community Health Centers Special Fund (cigarette taxes) which reimburses federally qualified health centers for comprehensive primary care services provided to the uninsured/underinsured population, statewide.

Item 8 Other Federal Funds. The amount actually expended for the category "Other Federal Funds" was \$9,242,204 less than what was budgeted for under this category. The primary reason for this variance is that the amount that was budgeted for the WIC grant in fiscal year 2011 was \$35,703,564, however the actual amount expended was \$30,472,939.

SIGNIFICANT BUDGET VARIATIONS -- FORM 4 (FISCAL YEAR 2011)

Item I. b. Infants < 1 year old. The amount budgeted for the category "Infants < 1 year old" was \$2,902,244, and the actual amount expended was \$1,217,838, a difference of \$1,684,406. This variance is due to an overestimation of the budget ceiling for the Early Intervention Special Fund. (The budget ceiling for the Early Intervention Special Fund under this category was established at \$775,000, however only \$135,769 was expended). Further, a total of \$818,400 in TANF funds was budgeted for the Healthy Start Program, however TANF funds were eliminated in fiscal year 2011.

Item I. c. Children 1 to 22 years old. The amount budgeted for the category "Children 1 to 22 years old" was \$4,871,990, and the amount actually expended was \$4,017,854, a difference of \$854,136. The primary reason for the variance is the elimination of TANF funds for the Healthy Start Program. A total of \$501,600 in TANF funds were budgeted for the Healthy Start Program under this category, however these funds were eliminated in fiscal year 2011.

Item I. f. Administration. The budgeted amount for the category "Administration" was \$1,259,577, and the amount actually expended was \$1,117,869, a difference of \$141,708. The variance is primarily due to an overestimation of the budget ceiling for Title V related expenditures falling under this category.

SIGNIFICANT BUDGET VARIATIONS -- FORM 5 (FISCAL YEAR 2011)

Item II. Enabling Services. The budgeted amount for the category "Enabling Services" was \$10,384,140, however the amount actually expended was \$8,152,920, a difference of \$2,231,220. One of the major contributing factor related to this variance is the overstated budget ceiling for this category as it relates to the Early Intervention Special Fund. For

example, the planned budget for the Early Intervention Special Fund related to this category in fiscal year 2011 was \$1,562,500, however the actual amount expended amounted to \$273,729, a difference of \$1,288,771. Another major reason for this variance was the elimination of TANF funds for the Healthy Start Program in fiscal year 2011. For example, a total of \$873,840 was budgeted under this category for the Healthy Start Program, however no funds were expended.

Item III. Population-Based Services. The amount budgeted for the category "Population-Based Services" was \$1,813,754 in fiscal year 2011, whereas the actual amount expended was \$1,128,529, a difference of \$685,225. This was primary due to an overestimation of the budget ceiling for both the Early Intervention Special Fund and the Newborn Metabolic Screening Special Fund for this category. For example, a budget of \$685,088 was established for the Newborn Metabolic Screening Program for this category, however only \$564,327 was expended. Similarly, a budget of \$193,750 was established for the Early Intervention Special Fund and only \$33,942 was expended. In addition, a total of \$232,320 in TANF funds budgeted under this category for the Healthy Start Program was eliminated.

Item IV. Infrastructure Building Services. The budgeted amount for the category "Infrastructure Building Services" was \$6,550,883 in fiscal year 2011 and the amount actually expended under this category was \$5,410,886, a difference of \$1,139,997. The variance is primarily due to: a) the elimination of TANF funds that were budgeted under this category for the Healthy Start Program; b) position vacancies in the Birth Defects Monitoring Program; and c) an overestimation of the budget ceiling for Title V funds relative to infrastructure building services.//2013//

B. Budget

The State's maintenance of effort level from 1989 is \$11,910,549 and the State's overmatch in fiscal year 2010 is \$9,722,692. There is no continuation funding for special projects or special consolidated projects in fiscal year 2011.

Significant Budget Variations -- Form 3 (Fiscal Year 2011)

The "Federal Allocation" category for fiscal year 2011 amounts to \$2,274,139. This figure is based on the fiscal year 2010 grant award since the final grant award for fiscal year 2011 has not yet been determined.

The category "Unobligated Balance" is estimated to be \$499,384 which slightly more than the fiscal year 2010 amount of \$437,770.

As in fiscal year 2010, a significant budget variation in fiscal year 2011 pertains to the category "State Funds." The Family Health Services Division ("FHSD") had reduction-in-force ("RIF") and vacant position abolishments affecting 61.75 permanent full-time equivalency ("FTE") positions in fiscal year 2011. State employees have also been placed on twice-a-month work furlough for the period October 2009 to June 2011. Due to the continued stagnation of the State's economy, FHSD received State general fund reductions of 4.81%, or \$3,760,960, in fiscal year 2011. This is in addition to State general fund reductions of 44%, or \$19,715,324, it received in fiscal year 2010.

The fiscal year 2011 reductions are primarily due to executive and legislative action as follows:

- \$2,773,618 - Reduction-in-force and vacant position abolishments affecting 61.75 permanent full-time equivalency positions
- \$685,726 - Reductions for purchase of service contracts. These reductions will impact upon two rural hospital operating subsidies (\$300,000); family planning services (\$192,863); and

psycho-social (parenting) services (\$192,863).

- Twice-a-month work furlough

As indicated in last year's grant application, the most significant budget reduction involved the loss of \$11,563,000 in fiscal year 2010 State general funds for the Healthy Start Program. In fiscal year 2011, the Healthy Start Program has dwindled down to one State funded position and approximately \$1,320,000 in TANF funding for home visiting contracts with YWCA of Hawaii Island for \$670,000, and Child and Family Services (Leeward Oahu) for \$650,000. The Healthy Start Program also receives a federal grant of \$672,605 to support evidence-based home visitation programs to prevent child maltreatment. Finally, the 2010 Hawaii State Legislature appropriated \$1.5 million from the State's emergency and budget reserve fund under Senate Bill 2469 to supplement the Healthy Start Program. This measure, however, has not been signed into law by the Governor as of this writing.

The "Other Funds" category has decreased by \$687,297 from fiscal year 2010 to fiscal year 2011. The decrease is primarily due to the elimination of TANF funding for family planning services.

Finally, the category "Program Income" has decreased by \$3,032,574 from fiscal year 2010 to fiscal year 2011. The decrease in Program Income is primary due to the elimination of \$3 million in Tobacco Settlement funds for the Healthy Start Program in State fiscal year 2011.

Significant Budget Variations -- Form 4 (Fiscal Year 2011)

There is an overall decrease of \$7,419,529 for all budget categories from fiscal year 2010 to fiscal year 2011 as it relates to Form 4. As mentioned in the budget narrative related to Form 3, the decrease is due to executive and legislative reductions in State funds, program income, and other funds for fiscal year 2011.

Significant Budget Variations -- Form 5 (Fiscal Year 2011)

As with Form 4, there is an overall decrease of \$7,419,529 for all budget categories from fiscal year 2010 to fiscal year 2011 as it relates to Form 5. As mentioned in the budget narrative related to Form 3, the decrease is due to executive and legislative reductions in State funds, program income, and other funds for fiscal year in 2011.

/2012/ The State's maintenance of effort level from 1989 is \$11,910,549 and the State's overmatch in fiscal year 2012 is \$12,074,495. There is no continuation funding for special projects or special consolidated projects in fiscal year 2012.

Significant Budget Variations -- Form 3 (Fiscal Year 2012)

Item 1. Federal Allocation. The "Federal Allocation" category for fiscal year 2012 amounts to \$2,270,185. This is based on the fiscal year 2010 grant award since the final grant award for fiscal year 2011 has not yet been determined.

Item 2. Unobligated Balance. The category "Unobligated Balance" is estimated to be \$475,518 which slightly less than the fiscal year 2011 amount of \$499,384.

Item 3. State Funds. In fiscal year 2012, there was an increase of \$2,351,803 from fiscal year 2011 in the category "State Funds." This increase is primarily due to a legislative appropriation of \$2,124,192 to cover shortfalls in purchase of service funding for early intervention services. The Family Health Services Division received budgetary restrictions of \$327,000 for contracted health and human services programs in fiscal year 2012. Although furloughs were eliminated in State fiscal year 2012, there was a 5% reduction in compensation for all positions in fiscal year 2012.

Item 5. Other Funds. The "Other Funds" category has decreased by \$1,622,984 from fiscal year 2011 to fiscal year 2012. The decrease is primarily due to the elimination of TANF funding for the Teen Pregnancy Project and Family Planning Program, and funding for the Full Inclusion and Keiki Care programs.

Item 6. Program Income. Finally, the category "Program Income" has decreased by \$677,609 from fiscal year 2011 to fiscal year 2012. The net decrease in Program Income is primary due to the elimination of \$1 million in Tobacco Settlement funds for the Early Intervention Program in fiscal year 2012.

Significant Budget Variations -- Form 4 (Fiscal Year 2012)

Item I.a. Pregnant Women. There is an increase of \$301,386 from fiscal year 2011 to fiscal year 2012 as it relates to the category "Pregnant Women." This is attributed to an increase in funding for purchase of service contracts related to primary care services to uninsured/underinsured individuals from the community health centers special fund. The community health centers special fund was established via the enactment of Act 316 in 2006 (cigarette tax legislation). The funds are to be utilized for the operations of FQHCs.

Item I.b. Infants < 1 year old. In fiscal year 2012, there is a decrease of \$1,082,845 from fiscal year 2011 for the category "Infants < 1 year old." This decrease is attributed to the loss of TANF funding for the Healthy Start Program in fiscal year 2012.

Item I.d. Children with Special Healthcare Needs. There is a net increase of \$621,923 from fiscal year 2011 to fiscal year 2012 as it relates to the category "Children with Special Health Care Needs." The increase is attributed to a legislative increase of \$2,124,192 for purchase of service contracts for early intervention services in fiscal year 2012. This increase has been mainly offset by the loss of \$1 million in Tobacco Settlement funding for purchase of service contracts related to early intervention services and a decrease of \$464,584 in the early intervention special fund for this budget category.

Significant Budget Variations -- Form 5 (Fiscal Year 2012)

Item III. Population-Based Services. There is a decrease of \$342,236 in the category "Population-Based Services" from fiscal year 2011 to fiscal year 2012. This is mainly attributed to a decrease in anticipated revenues for the early intervention special funds to be used for population-based services related to the categories "Infants < 1 years old" and Children 1 to 22 years old."

There are no other significant budget variations for Form 5.//2012//

/2013/ The State's maintenance of effort level from 1989 is \$11,910,549 and the State's overmatch in fiscal year 2012 is \$11,875,399. There is no continuation funding for special projects or special consolidated projects in fiscal year 2013.

SIGNIFICANT BUDGET VARIATIONS -- FORM 3 (FISCAL YEAR 2013)

Item 1. Federal Allocation. The "Federal Allocation" category for fiscal year 2013 amounts to \$2,229,698. This is based on half of the Title V federal awards received for fiscal year 2012 multiplied by two to obtain the estimated award for fiscal year 2013.

Item 2. Unobligated Balance. The category "Unobligated Balance" is estimated to be \$93,332 which is significantly less than the fiscal year 2012 amount of \$475,518. The decrease in the unobligated balance is due to higher personnel related costs such as the increase in fringe benefit rate from 38.84% to 39.76% and the elimination of employee

furlough savings in fiscal year 2012.

Item 6. Program Income. Although there were no significant variances in the category "Program Income" from fiscal year 2012 to fiscal year 2013, of worthy note is the appropriation of \$250,001 in Tobacco Settlement Funds by the 2011 Hawaii State Legislature for childhood obesity prevention services.

SIGNIFICANT BUDGET VARIATIONS -- FORM 4 (FISCAL YEAR 2013)

Item I. a. - f. No significant variances in any category between fiscal year 2012 and fiscal year 2013.

SIGNIFICANT BUDGET VARIATIONS -- FORM 5 (FISCAL YEAR 2013)

Items I -- IV. No significant variances in any category between fiscal year 2012 and fiscal year 2013.//2013//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.