Maternal and Child Health Services Title V Block Grant

State Narrative for Hawaii

Application for 2010 Annual Report for 2008

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Table of Contents

I. General Requirements 4
A. Letter of Transmittal 4
B. Face Sheet 4
C. Assurances and Certifications 4
D. Table of Contents 4
E. Public Input 4
II. Needs Assessment 6
C. Needs Assessment Summary 6
III. State Overview 9
A. Overview 9
B. Agency Capacity 26
C. Organizational Structure 37
D. Other MCH Capacity 38
E. State Agency Coordination 41
F. Health Systems Capacity Indicators 49
Health Systems Capacity Indicator 01: 49
Health Systems Capacity Indicator 02: 51
Health Systems Capacity Indicator 03: 52
Health Systems Capacity Indicator 04: 54
Health Systems Capacity Indicator 07A: 55
Health Systems Capacity Indicator 07B: 57
Health Systems Capacity Indicator 08: 58
Health Systems Capacity Indicator 05A: 59
Health Systems Capacity Indicator 05B: 61
Health Systems Capacity Indicator 05C: 62
Health Systems Capacity Indicator 05D: 62
Health Systems Capacity Indicator 06A: 63
Health Systems Capacity Indicator 06B: 64
Health Systems Capacity Indicator 06C: 65
Health Systems Capacity Indicator 09A: 66
Health Systems Capacity Indicator 09B: 68
IV. Priorities, Performance and Program Activities 70
A. Background and Overview 70
B. State Priorities 71
C. National Performance Measures 74
Performance Measure 01: 74
Performance Measure 02: 78
Performance Measure 03: 81
Performance Measure 04: 84
Performance Measure 05: 88
Performance Measure 06: 91
Performance Measure 07: 95
Performance Measure 08: 98
Performance Measure 09: 101
Performance Measure 10: 105
Performance Measure 11: 109
Performance Measure 12: 113
Performance Measure 13: 116
Performance Measure 14: 120
Performance Measure 15: 123
Performance Measure 16: 126
Performance Measure 17: 130
Performance Measure 18: 134

D. State Performance Measures 138
State Performance Measure 1: 138
State Performance Measure 2: 141
State Performance Measure 3: 145
State Performance Measure 4: 149
State Performance Measure 5: 152
State Performance Measure 6: 155
State Performance Measure 7: 159
State Performance Measure 8: 162
State Performance Measure 9: 166
E. Health Status Indicators 169
Health Status Indicators 01A: 169
Health Status Indicators 01B: 170
Health Status Indicators 02A: 171
Health Status Indicators 02B: 171
Health Status Indicators 03A: 172
Health Status Indicators 03B: 173
Health Status Indicators 03C: 175
Health Status Indicators 04A: 176
Health Status Indicators 04B: 177
Health Status Indicators 04C: 178
Health Status Indicators 05A: 179
Health Status Indicators 05B: 180
Health Status Indicators 06A: 181
Health Status Indicators 06B: 182
Health Status Indicators 07A: 182
Health Status Indicators 07B: 183
Health Status Indicators 08A: 184
Health Status Indicators 08B: 185
Health Status Indicators 09A: 186
Health Status Indicators 09B: 188
Health Status Indicators 10: 189
Health Status Indicators 11: 190
Health Status Indicators 12: 191
F. Other Program Activities 192
G. Technical Assistance 194
V. Budget Narrative 195
A. Expenditures 195
B. Budget 199
VI. Reporting Forms-General Information 205
VII. Performance and Outcome Measure Detail Sheets 205
VIII. Glossary 205
IX. Technical Note 205
X. Appendices and State Supporting documents 205
A. Needs Assessment 205
B. All Reporting Forms 205
C. Organizational Charts and All Other State Supporting Documents 205
D. Annual Report Data 205

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.

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 by contacting:

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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 March 2009; expires March 31, 2012.

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.

Generally, feedback on the report from past public meetings indicate that the document is too lengthy and cumbersome for use by the general public.

The Title V agency public information officer is reviewing the national MCH Bureau report on public input efforts by other state Title V agencies. Recommendations will be discussed later this year with senior management as part of planning discussions for the next mandated 5 year

maternal child health needs assessment. A link to the National Title V website may be placed on the Hawaii Department of Health website along with other user-friendly summary documents.

/2009/ Information on the Title V report and a link to Title V information system is being placed on the Department of Health (DOH) website.

To engage stakeholders to provide input to the Title V annual report and needs assessment, the Title V agency is working on the development of an MCH Databook that will highlight 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 will be used in the publication. The document will also include descriptive data on the MCH population, including some of the Title V Health Status Indicator data.

The Title V agency is also developing a series of user-friendly fact sheets on key issues for the perinatal population utilizing 6-years of PRAMS data. Based on the feedback from stakeholders, more fact sheets can be developed for other MCH population groups.

Both the databook and fact sheets will be placed on the DOH website and will be disseminated to stakeholders. Dr. Hayes, the Title V agency's new Centers for Disease Control-assigned epidemiologist, is providing guidance for the projects. //2009//

/2010/Public input activities continue as described in previous years. 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.

Title V continues to focus on disseminating data and information from the Title V report in more user-friendly formats. Title V 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 Title V needs assessment. An additional 500 copies were printed and are being distributed to partner agencies and programs.

The Family Health Services Division Program Profiles publication will be completed for distribution in August 2009. The report is intended to serve as a reference for data on key MCH population health indicators and also provide a description of programs and activities within the Title V agency that help improve the health outcomes tracked by Title V. Many of the Title V performance measures and indicators are featured in the publication.

A series of fact sheets will be developed for each of the state priority health issues identified through the current Title V needs assessment to educate and mobilize stakeholders to participate in the development of action plans and to support implementation.

All data publications will be placed on the DOH website.//2010//

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Hawai‘i Maternal Child Health Priorities

Nine priority issues were identified through the Title V maternal and child health (MCH) needs assessment (NA) process. These priorities are 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 (2005-2010). The 9 priorities for the state MCH population are:

1. Reduce the rate of unintended pregnancy (continuing priority)
2. Ensure that all infants and children receive appropriate and timely hearing evaluation and early intervention services (continuing priority)
3. Prevent overweight and obesity in children (continuing priority)
4. Improve the oral health of children (continuing priority)
5. Prevent underage drinking among adolescents
6. Reduce the rate of adolescent Chlamydia
7. Increase abstinence from alcohol use during pregnancy
8. Increase abstinence from smoking during pregnancy
9. Improve transition services to adult life for youth with special health care needs

Summary of Needs Assessment Process

The NA process was managed by a Steering Committee comprised of FHSD senior management to provide guidance, assure progress, and coordinate efforts between work groups. A work group was established for each of the three target populations: 1) Women and Infants (WI), 2) Child and Adolescent (CA), and 3) Children with Special Health Care Needs (CSHCN).

The NA process involved several steps:

• Evaluation of previous needs assessment process and priorities
• Problem definition: identify preliminary list of health issues
• Prioritization: identify final list of priorities utilizing specific criteria scoring
• Problem Analysis: identify key goals, targeted behaviors, determinants/influencing factors, existing services & interventions using a logic model format
• Activities/Plan

Input from stakeholders was collected for all steps in the process using videoconferencing, email, telephone conference calls, community meetings, focus groups, coalition meetings and interviews. The process has helped to identify new stakeholders and improve working relationships with existing agency partners.

The CSHN work group was able to complete enough of the NA to develop a plan and secure grant funding for the two CSHN priorities: hearing and transition services. The WI and CY work groups will continue to refine the problem analysis/logic models in conjunction with stakeholders and utilize the findings for future planning.

The Title V Steering Committee will continue to provide guidance to the ongoing NA process to assure progress over the next five years because of limited numbers of staff available to work on the new priority issues.

On-Going Needs Assessment Work

Progress on the priority issues continued over the past year. Updates can be found in the narratives for the 9 state measures used to track progress on the state MCH priorities.

Planning for Next 5-Year Needs Assessment
The Title V Steering Committee and key program staff will begin planning for the next NA (due in 2010) with a training in July 2007 from Juan Acuna, MD, MPH, Medical Epidemiologist and MCH EPI Team Leader with the Centers for Disease Control's (CDC) Division of Reproductive Health. Dr. Acuna will be presenting on "How to use data to inform program planning." He is also scheduled to meet with the 3 Division branches to assess and discussion data analysis needs and issues.

Dr. Acuna is visiting Hawaii to establish a new CDC-assigned epidemiologist position at the Title V agency to assure the program develops greater access to and utilizes the key MCH datasets for policy development and progam planning. The position will be paid from Title V funding. The former Title V CDC-assigned epidemiologist, Dr. Cheryl Prince, returned to CDC in September 2005. Efforts to establish a state epidemiologist position has been delayed in administrative reviews, thus negotiations were started to secure another assignee.

NA planning meetings will be scheduled shortly once the new CDC-assigned Title V epidemiologist, Dr. Don Hayes, begins his new position.

/2009/ Dr. Hayes began work with the Title V agency. Dr. Acuna provided Title V agency staff with an overview on the importance of needs assessment through his presentation held in July 2007. Arrangements are being made to conduct a 2-day training with Dr. Acuna in October 2008 during this next site visit.

In June, program staff provided progress reports to Division management on efforts to address the 9 state priority issues. The PowerPoint presentations were posted on the Department intranet for use by staff. Updates can be found in the nine state performance measure narratives.

In August several Title V staff will be attending a 3-day training on Public Health Core Skills Development. The training is sponsored by the DOH Injury Prevention Program and the Chronic Disease Management Branch. The trainings will focus on the "Getting to Outcomes" framework which was designed to help increase capacity of prevention programs through effective planning, implementation and evaluation. Lessons from the training will be incorporated into the NA planning.

Planning for the NA will be completed by the end of 2008. The process utilized in the last NA will be used again for this NA. The October NA training will kick-off formal planning efforts and a Division-wide meeting is scheduled for November 2008 to present the timeline and major activities. Compiling external stakeholder input will begin shortly thereafter.

In preparation for the NA, an MCH databook is being developed utilizing key MCH datasets with a focus on the current state Title V priority health issues. The document will also include other population-based health measures and descriptive data. A series of fact sheets are being developed utilizing PRAMS data. The databook and fact sheets will help engage more stakeholders to provide input to the NA.//2009//

/2010/
NA Plan/Timeline
The timeline is: Issue Identification (Jan-May 2009), Division Priority Setting (June 2009), Problem Analysis (Jun-Nov 2009), Strategy Design (Nov-May 2010).

Issue Identification
FHSD began work on the NA at the November Division meeting. NA training was conducted in January 2009. The 3 population workgroups (CSHN, Women/Infants,

Children/Youth) compiled/reviewed stakeholder input, reviewed data, and assessed capacity to develop a short-list of issues for consideration by the NA Steering Committee. The perinatal fact sheets publication was completed using PRAMS, hospital discharge data and vital statistics. The FHSD Profiles, which contains MCH data, will be published in August 2009.

Priority-Setting
In June 2009 the Steering Committee identified 8 state priority issues: Bullying, Child Abuse & Neglect, Child Obesity, Prenatal Alcohol Use, Unintended Pregnancy, Access to Specialty Care on the Neighbor Islands for CSHN, Identification of Children with Developmental Delays, and Transition to Adult Healthcare for YCHCN.

Next Steps in Needs Assessment Process
In June Dr. Acuna conducted a training on problem analysis for 70 staff and a few key stakeholders. Work on problem analysis will continue. Strategy design will begin at a November stakeholders meeting.//2010//

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, Oʻahu, and Kauaʻi (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 71% of the state population resides in the City and County of Honolulu on the island of Oʻahu, concentrated in the Honolulu metropolitan area. The neighbor island counties are Hawaii, Kauaʻi (includes Niʻihau) and Maui (includes Molokaʻi, Lanaʻi, and Kahoʻolawe, 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 Oʻahu. Consequently, neighbor island and rural Oʻahu residents often must travel to Honolulu for these services. Interisland passenger travel is entirely by air. Air flights are frequent, but comparatively expensive. Three of the ten most expensive airfares per mile in the U.S. are the connections between Honolulu and Maui, Honolulu and Kona (on Hawaii island), and Honolulu and Kauaʻi. This creates a financial barrier for neighbor island residents since round-trip airfare costs range from $140-$200.

/2007/ In June 2006 a new low-cost airline carrier entered the market becoming the third interisland jet carrier in Hawaii. With new competition, airfare costs have begun to drop substantially, although seats on the new airlines are limited at this time.//2007//

/2008/ Due to increased competition average airfares are about $80 per round-trip. A new inter-island ferry service for passengers and cars will link the state's major islands beginning in late summer of 2007. One-way fares for passengers will run from $42-$65 per person and $59-$69 per car/SUV.//2008//

/2009/ In April Hawaii's 2nd largest inter-island airline carrier entered bankruptcy and stopped passenger service resulting in a loss of 88,000 seats per week. While the state's 2 other carriers will make up 56,000 of those seats; ticket prices are increasing.

Superferry inter-island service began in April after legal delays and poor ocean conditions. The 866-passenger vessel offers residents a transportation option given the airline closure.//2009//

/2010/ The Hawaii Superferry terminated interisland services in March 2009, as the Hawaii Supreme Court struck down legislation allowing the ferry to operate without an Environmental Impact Statement. While this was a victory for environmentalists which believe the ferry posed a threat to whales and the islands native ecosystem; this was a blow to the overall state's economy which is in a fragile state. It also eliminated an inter-island travel option for families seeking speciality healthcare on Oahu.//2010//

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 hospital, specialty, and subspecialty services are available. Because of the mountainous nature of the islands, road networks have been sparse and, in some places, limited to a single highway near the coast. Access to emergency care on neighbor islands often requires the use of helicopters or fixed-wing aircraft.

DEMOGRAPHICS

According the 2000 Census estimates, 1.2 million residents live in Hawaii up 9.3% from 1990. Maui County grew the most, up 27.6% to 128,094 residents; followed by Hawaii County with a 23.6% increase to 148,677; and Kaua‘i County with a 13.5% increase to 58,610. Honolulu registered the least growth by county at 4.8% with 876,156 people. Recent census estimates show neighbor island populations continue to grow faster than Honolulu.

Hawaii's population continues to grow steadily yet slowly at an average rate of 1.1% since 2002. That followed six years of growth below 1% from 1995 to 2001.

/2007/ Hawaii's population continues to increase at a steady rate, about 1% for the past 4 years after 6 years of slow growth. In 2005, Hawaii ranked the 18th state in the nation for population growth, according to the U.S. Census. The islands' population has increased by about 13,000 every year for the past five years. Demographers attribute this increase to more births than deaths and to some 3,400 people who migrate to Hawaii each year.

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, but its share of residents is dwindling: from 72.3% in 2000 to 71.2% in July 2004. Nearly 13% of Hawaii's people were estimated to be living on the Big Island in July 2004, 11% in Maui County, and almost 5% on Kaua'i.//2007//

Hawaii's population, like the U.S. as a whole is aging. The median age of Hawaii residents increased from 32.6 to 36.2 over the last decade, higher than the national average of 35.3. The numbers of residents age 65 and over was up by 28% from 1990. But, the fastest growing age categories were in the 75-84 group (up 61%) and the 85 and over group (up 69%). The percentage of children age 0-5 years decreased by 6.1% from 1990. Decreases also occurred among young adults ages 20-24 (down 8.1%) and 25-34 (down 14.7%).

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 62% of the state's population according to the 2000 Census. Some 21.4% of the people in Hawaii indicate they are of two or more races.

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, 16% of Hawaii's 1.2 million population is foreign-born, with just more than 61,000 immigrants legally admitted into the state between 1991 and 1998. Estimates of illegal immigrants in Hawaii range from 6,000 to 9,000.

Because of this ethnic diversity, there are a number of people who speak English as a second language. In 2003, approximately 7.8% (13,791) of the state's public elementary school children were enrolled in the Students with Limited English Proficiency Program, an increase of 44% since 1990. According to a 1999 report of the Governor's Council on Literacy, 154,000 or more than 20% of Hawaii's adults are functionally illiterate. The 2000 Census reports that 254,172 people in Hawaii speak a language in the home other than English.

ECONOMY

Hawaii is enjoying its strongest economy since the early 1990s, driven largely by active real

estate, construction and tourism sectors. Hawaii's heavily dependent tourism economy was devastated by the 2001 terrorist attacks, the SARS (Severe Acute Respiratory Syndrome) outbreak in China, and initiation of the Iraq war.

Overall, Hawaii's economy continues to hinge on visitor arrival growth. In 2004 the state hit a near record high of 6.9 million visitors. The state's unemployment rate of 2.7% reported for May 2005 is the lowest in 14 years and the lowest in the nation. Hawaii experienced job growth of 2.6% or 14,800 jobs in 2004. Real personal income rose 2.6% and has grown by 2.9% in the first quarter of 2005 (a 6.9% increase from a year earlier). Bankruptcy filings have also declined by 14%.

General fund revenues for the first 10 months of the state fiscal year are running 14.6% ahead of the previous year according to the state tax office in May 2005. General excise tax collections, the largest category of collections, were up 10%, the hotel room tax collections were up 7.9% and individual tax collections were up 15.8%. All of the economic indicators are pointing to a robust economy.

/2007/ In 2005 Hawaii's economy remained strong. The state experienced another record year of visitor arrivals (7.39 million visitors with estimated spending of $11.5 billion) and continues to maintain the lowest unemployment rate in the U.S. through 2006 for the 24th straight month (2.8% in April 2006 compared to the national jobless rate of 4.7%). Hawaii's gross state product expanded 4.8% in 2005, making it one of the top 20 states in terms of economic growth, according to a U.S. Commerce Department. Employment was up 3.7% in 2005 from 2004 and State General Fund revenues increased by 16.4% compared with the previous year. The U.S. Bureau of Economic Analysis's (BEA) estimate of Hawaii's nominal personal income increased 7.0% in 2005, following a big 8.0% increase in 2004.

In 2006, however, economists anticipate the pace of economic growth in the state will be more moderate in light of a tight labor market, slowing 2006 visitor arrivals, and rising energy and housing costs. //2007//

/2008/ While Hawaii's economy is still experiencing moderate growth, the state economy is starting to slowdown. After 2 years of record breaking visitor arrivals in 2004 and 2005, the total arrivals for 2006 were flat, matching arrival figures in 2005, while total visitor days declined slightly. In 2006 Hawaii continued to maintain the lowest unemployment rate in the U.S. (2.4%). Personal incomes in Hawaii have grown by 6.3%, but the inflation rate for 2006 was 5.9%, bringing the amount of real income gain to 0.4%. In 2006, State general fund tax revenues amounted to $4,521.8 million, a $269.6 million or 6.3% increase over 2005.//2008//

/2009/ Hawaii's economy continues to slow with the closure of an inter-island airline (with 1,900 employees), ATA airlines, Molokai Ranch (the island's largest employer), and the loss of 2 NCL cruise ships. In 2007 visitor arrivals dropped by 1.2%, the first decline since 2003. The 2007 jobless rate (before the major layoffs) was 2.8%. The figure for May 2008 reached a 4-year high (3.5%). Personal income remained steady at 6% growth in 2007, with inflation decreasing to 4.8%.

Economists forecast reduced visitor growth, net job losses, lower real income growth and higher inflation for 2008.//2009//

/2010/ The State Council of Revenues revised in March its earlier projection of a -5% to a -9% growth rate for Hawaii. This equates to a $2.7 billion shortfall over the next 2 years. This is a complete reversal from last fiscal year when the state experienced a $330M surplus. The Department of Health (DOH) sustained an 8% cut to its state funded revenues. In addition, on June 1, 2009 Governor Lingle ordered a 3-day a month furlough for state workers for the next 2 years. This plan is expected to be challenged by the Hawaii Government Employees Association with court action.

The overall recession nationally is having a negative impact on Hawaii's primary economy driver, tourism. Hotel occupancy rates are at 64% statewide and as low as 50% in some counties. Reduction in hotel occupancy rates have been impacted by reduced leisure travel and convention bookings, and fears related to the spread of HINI swine flu. Bankruptcy filings have increased by 62%. Unemployment is at a 6 year high at 6.9%. Honolulu was recently listed as the second most expensive city to live in the United States, just behind Manhattan.

Another factor affecting the economy and departmental operations is the H1N1 Influenza. Hawaii has 189 confirmed cases. The Department has investigated and conducted case follow-up for over 1100 individuals tested for Influenza A. Of the specimens tested positive for Influenza A, 5-10% were novel H1N1 of swine flu origin, 5-15% were seasonal H1 influenza, and 80-90% were seasonal H3 influenza.//2010//

HIGH COST OF LIVING

Despite the generally positive outlook, a byproduct of economic growth is rising inflation that tempers gains made in personal earnings. Consumer prices rose 3.3 % last year mostly due to higher housing and energy prices. In May 2005, Hawaii surpassed California and has the highest gas prices in the U.S., according to Triple A. Hawaii's average price remains just below a peak of $2.554 a gallon with slightly higher rates on the neighbor islands.

/2007/ Hawaii continues to maintain some of the highest gas prices in the U.S. daily statewide average for gas as reported by AAA's Fuel Gauge Report has ranged from $3.38 to $3.43 a gallon, with the average settling at $3.41. The national average over the same time has been about $2.88 a gallon.//2007//

/2008/ Hawaii continues to maintain some of the highest gas rates in the U.S. Although fuel prices nationally have risen faster in 2007 than in Hawaii, the average state rate per gallon is still 35 cents above the national average. //2008//

/2009/ Hawaii's gas prices ranked 6th highest in the nation according to Triple A, with an average of $4.24 per gallon in June. //2009//

/2010/ Hawaii enjoyed a reduction in gas prices to $2.40 a gallon, but most recently the prices have begun to rise again to an average price of $2.89 in Honolulu County. For the neighbor islands, depending on the county, the cost per gallon can be as high as $4.//2010//

The major inflation driver is Hawaii's housing costs. In April 2005, the highest median single-family home prices were on Maui at $696,000; followed by O‘ahu at $545,000; Kaua'i at $540,000; and Hawaii island at $370,000. Even on the small rural island of Moloka‘i with the highest unemployment rate, the average price home sold for $200,000.

The highest median condo prices in the state were on Kaua'i at $418,000, followed by Hawaii island at $397,000, Maui $330,000, and $243,000 on O‘ahu. With the median income for a family of four at roughly $71,320 (2003); the cost of home ownership is becoming out of reach for many families. According to 2004 Census estimates, Hawaii's homeownership rate was 58%, the third lowest in the U.S. in 2004.

/2007/Hawaii housing costs continued to increase, but in mid-2006 began to drop while the number of home sales continued to decrease. Again, the greatest increases in housing costs were on Maui. In May 2006, the median price for a single-family home on Maui was $758,000 and $599,500 for a condo. O‘ahu's median single-family home price was $668,300 while the median condo sale price was $306,000. //2007//

/2008/ In 2006 Hawaii's housing costs began to flatten, reflecting the general slowing of the state

economy. //2008//

/2009/ Hawaii's housing market has been spared the effects of sub-prime mortgage foreclosures. Although, foreclosures did rise by 52% in the state's largest housing market (compared to the national average of 112%), Honolulu ranked 2nd lowest among the top 100 major U.S. cities in January 2008. Home sales have generally slowed in the past year with modestly lower sale prices.//2009//

/2010/ Hawaii's housing market has been affected by recession. Home prices have fallen by 15.3%; the average cost of a single family home fell from $649,500 to $550,000. Hawaii's foreclosure rate more than doubled this year. //2010//

Limited housing supply coupled with high demand is likely to keep housing prices rising and the market strong for at least the next one to two years. The buying boom has reduced the rental inventory and driven up rents, squeezing the most vulnerable sectors of society. Renters make up about 40% of the state's population, the third highest nationally. Low-income renters are hardest hit. In a 2004 report, the National Low Income Housing Coalition called Hawaii the 7th least affordable state in the country. Residents need to make at least $17.60 an hour to afford a two-bedroom rental.
/2007/ The National Low Income Housing Coalition (NLIHC) in 2005 ranked Hawaii the most expensive for renters in the U.S., the first time the state has topped the annual list. Hawaii renters had to earn about $46,400 this year to afford a two-bedroom apartment -- nearly $10,000 more than in 2004, according to the study. //2007//

Moreover, the City of Honolulu in May 2005 stopped accepting applications for federal rental housing assistance with a waiting list of about 10,500 people. The state program on O‘ahu stopped placing names on its waiting list in 1999, yet there are still over 1,000 people waiting for vouchers. Homeless agencies fear a swelling population of people on the verge of homelessness. The University of Hawaii Center on the Family estimated that the state's homeless population was 13,000 last year, based on the number who used shelters or received outreach services.

POLITICAL CONTEXT
This has been the third legislative session under Republican Governor Linda Lingle's administration. The major themes have been identifying solutions and funding for substance abuse prevention, treatment and prosecution, long term health care, and early childhood education. Increased revenues provide an opportunity to fund initiatives supported by the Governor. However, spending is still cautious, especially with union arbitrated salary increases for public employees at 5%, and teachers at 9.6%. Tobacco Settlement funds have been pulled back from the Healthy Start program with no replacement of the $5M with general fund revenues. The program will rely upon Medicaid generated funds and Temporary Assistance for Needy Families (TANF) to assure that families are not without services. However, Healthy Start has been asked to review its program model to streamline cost and improve effectiveness. On a national level, the threat of the loss of the Preventive Health Block Grant will have implications on the State's ability to address injury prevention.
/2007/ In response to rising energy and home costs, the Lingle administration shifted its policy focus this year to include energy self-sufficiency, affordable housing, and homelessness. The Administration continues to work on expanding the state's emergency preparedness, particularly in light of the Islands' isolation from assistance in the case of natural disaster and vulnerability to infectious diseases from other countries. //2007//
/2008/ Homelessness continues to be of concern to the Lingle administration. In response to the growing population of individuals living on the beaches in the Leeward Coast, Governor Lingle has directed her cabinet to develop viable solutions to revitalize the economy for this part of Oahu. An interdepartmental task force was convened in 2006 to conduct a needs assessment. Recommendations will be completed by July 2007. A new homeless shelter was established in the community to move families off of the beaches. Homeless services for the area and throughtout the state continued be to coordinated through private-public partnerships.

Disaster preparedness continues to be a top priority for the Director of Health. The department has launched a public awareness campaign to prevent the spread of disease and to be prepared for a pandemic situation. All divisions have been asked to develop Operational Plans in times of disaster.//2008//
/2009/ The Governor's focus this year was on energy independence, building an innovation economy, increasing affordable housing, and investing in Hawaii's infrastructure.//2009//
/2010/ The primary tension between the Governor and the legislature was decreasing revenues and strategies to balance the budget. The Governor does not support any tax increase nor the use of the state's Rainy Day Fund to off-set the growing deficit. Many programs within the DOH were reduced and the means of financing was changed from General Funds to Special Funds or the use of Temporary Assistance to Need Families (TANF) funds.//2010//

FELIX CONSENT DECREE
The Felix Consent Decree, issued in October 1994, has been the single major priority in the State's educational and health system for children, requiring enormous state appropriations and mobilization of staff to reach compliance with the terms of the decree to develop a system of care for children with special needs in accordance with Individuals with Disabilities Act (IDEA) and Section 504 of the Rehabilitation Act of 1973.

The Felix Consent Decree is the outcome of a 1993 lawsuit filed against the State in U.S. District Court on behalf of 7 children, their parents (guardians), and mental health advocates. The lawsuit alleged that qualified handicapped children were not receiving the educational and mental health service they needed and that the State was in violation of the law. The lawsuit was patterned after successful legal actions in the U.S., however, the Hawaii lawsuit involved all public schools in the state because Hawaii has a statewide unified public school system.

To avoid a federal takeover of the state school system or be placed into receivership, the State entered into the Consent Decree and waived all rights to appeal and agreed to fully implement a statewide system of care by June 30, 2000. The State did not meet the deadline and was found to be in contempt by the federal court. The Court set new compliance deadlines and identified a series of 56 benchmarks for the state to meet or face receivership of the educational system. In the effort, the Court granted the Directors of the State Education and Health Departments extraordinary powers to waive procurement laws, bypass state collective bargaining laws, and create new salaries levels for newly recruited special education teachers. The state was ordered to reach compliance without any consideration for costs.

Since 1994, the State has spent almost $1.5 billion on Felix related programs. The DOE's expenditures for Felix programs grew from $77.5 million in 1994 to $179.8 million in 2001 an increase of 132%. The DOH's general fund expenditures for Felix grew from $48 million in 1995 to $148.2 million in 2001, an increase of 209%. All this occurred at a time when Hawaii's economy was undergoing a crippling downturn. These costs do not include federal funds expended by DOH and expenditures by other agencies including the Attorney General's Office and DHS.

Felix Programs in the State Title V program (Family Health Services Division)are CSHNB Early Intervention Section (EIS) and MCHB Healthy Start, which focus on Part C of IDEA, early intervention services. DOH serves as the lead agency in Hawaii for Part C services. Hawaii has the most comprehensive definition in the nation of children to be served under Part C of IDEA. This definition provides eligibility for infants and toddlers with developmental delay in one or more areas, those with biological risk factors, and those at environmental risk. Hawaii is one of the few states to provide full entitlement under Part C to infants and toddlers with environmental risk factors. The Legislature appropriated funds to assure the statewide implementation of Healthy Start Early Identification and Home Visitation Program. The legislature has appropriated funds for EIS to meet the federal, state, and court mandates for services. Increases in referrals and early

identification of children with mental health needs (autism spectrum disorder) and intense level of interventions (individual behavioral supports) contribute the growing EIS costs.

In June of 2004, the State of Hawaii was declared to be incompliance with the Felix Consent Decree. However, court oversight will continue until December 2004, to document that the improvements made to the health and educational system for special education are sustainable.

In June 2005, the State of Hawaii was found to be fully compliant with Felix Consent Decree and released from court oversight.

The noteworthy health bills that passed in the 2005 legislative session include:

Tobacco permit
Requires retailers selling tobacco products to obtain a permit from the state Department of Taxation. Sets criminal penalties and forfeiture for retailers who sell tobacco without a permit. Will ensure accurate collection of tobacco taxes.

Early childhood education
Provides $50,000 for a task force to study how to improve quality and access to preschool.

Minimum Wage
Raises the minimum wage from $6.25 in 2006 and $7.25 in 2007.

Caregiver consent
Gives a minor's caregiver the right to consent to healthcare services for the minor; establishes requirement for caregiver consent affidavits.

Developmental disabilities, mental retardation
Makes an emergency appropriation to the state Department of Health for home and community based providers of services for those with developmental disabilities or mental retardation.

Early Intervention Services
Makes an emergency appropriation for additional funds from the Early Intervention Special Fund to the Family Health Services Division for services for infants and children up to age 3.

Healthy Start Task Force
SCR 13/45/168 mandates the Department of Health and the Department of Human Services continue their work on an interagency Task Force to increase coordination between the Hawaii Healthy Start child abuse prevention program and Child Welfare Services.

Healthy Start Review
HCR 227 requires the DOH to convene a Healthy Start (HS) advisory board to address various programmatic development issues within HS to increase overall program effectiveness and clarify the definition of successful outcomes for families served in HS.

Access to specialty care
Resolution requesting the State Health Planning and Development Agency to identify and evaluate the barriers to community-based access to specialty care and to make recommendations to improve access to specialty care on the neighbor islands and in rural O‘ahu.

Mental health
Expands the definition of "serious mental illness" that health insurance plans must offer coverage to include delusional disorder, major depression, obsessive compulsive disorder and dissociative disorder.

Graduated licenses

Creates a provisional driver's license between the permit and full license stages for those under 18; puts restrictions on the hours and number of passengers for those with provisional licenses; sunsets provisional licenses in 5 years.

/2007/ The noteworthy health bills that passed in the 2006 legislative session affecting the MCH population include:

Screening task force
SCR 70 HD1 requests the Director of Health to convene a task force to determine a means for a child to be screened prior to the start of the child's education at entry into preschool and elementary school, to provide for diagnosis, referral, correction or treatment, and to integrate the efforts of community and state organizations related to screening under a Hawaii Childhood Screening Initiative. The task force is to address screening tools, referral protocols, guidelines, and physician participation issues regarding developmental, behavioral/social-emotional, hearing, and vision screening for children age 0-8 years.

Early intervention services
Act 18 makes an emergency appropriation of $3,200,928 to the Department of Health for early intervention services (Early Intervention Section) for state fiscal year 2006.

Licensure of genetic counselors
SCR31 SD1 (adopted by both House and Senate) requests the auditor to conduct an analysis of proposed regulatory measures requiring professional licensure of genetic counselors.

Child Booster Seats
Act 175 requires use of a child safety seat or booster seat for children over 4 years but less than 8 years old riding in a motor vehicle.

Dental Coverage Assessment
Act 199 appropriates $90,000 to conduct an assessment of dental care coverage.

Underage Drinking penalties
Act 203 requires the suspension of driving privileges for persons under 21 years who illegally purchase, possess, or consume liquor.

Early Learning Educational Task Force
S.B. 3101 establishes and appropriates funds for an early learning educational task force to develop a five-year plan which will address a continuum of quality early learning opportunities for young children and maximize public and private resources.

Abortion Protections
ACT 35 reaffirms the State cannot deny or interfere with a woman's right to an abortion of a nonviable fetus or to protect the life and health of the female. Also repeals the 90-day residency requirement and allows the abortion procedure to be conducted in a clinic or physician's office.

Substance Use Services for Pregnant Women
Act 248 appropriates funding for a pilot clinic to provide comprehensive prenatal, delivery, & postpartum care & social services on the island of O‘ahu to women who have a history of methamphetamine & other substance use.

Infant Placentas
ACT 12 allows hospitals to release a human placenta to the mother or the mother's designee after determining it to be non-infectious.

Domestic Violence Fatality Review
Act 82 authorizes the Director of Health to establish teams to review domestic violence fatalities.

Fetal Alcohol Spectrum Disorder
Act 204 adds a position in the Department of Health to coordinate State programs on fetal alcohol spectrum disorder.

Family Planning Needs Assessment
HCR 226 requests DOH to convene working group to determine family planning funding needs for the 2007-2009 budget.

Comprehensive smoking ban
SB 3262 prohibits smoking in places open to the public and places of employment ensuring a consistent level of protection statewide from exposure to secondhand smoke including all state- and county-owned facilities, restaurants, bars, nightclubs, retail stores, shopping malls and public/common use areas in hotels.

Reimbursements for Telehealth
Act 219 ensures that telehealth services are reimbursable to assist in the delivery of effective and prompt healthcare, particularly to individuals residing in rural communities.

Pandemic Influenza Preparedness
Act 84 appropriates $11 million in funds to prepare for pandemic of influenza.

Emergency Medical Services
Act 85 appropriates $7 million for ambulance service contracts and helicopter medical transport services.

Other legislative related matters:

Early intervention services for children age 3-5 years
Although SB 2724 SD2 HD1 did not pass, it establishes a task force to research, design, and develop an implementation plan to develop a program for children age 3-5 years with developmental delays. Under Part B and C of the Individuals with Disabilities Education Act of 2004 (IDEA), states have the flexibility to provide services to children eligible to receive Part B services and who previously received services under Part C until the children are eligible to enter kindergarten, provided that the program includes an educational component that promotes school readiness and incorporates pre-literacy, language and numeracy skills. The Hawaii Early Intervention Coordinating Council (HEICC) is planning to address this 3-5 issue through a HEICC subcommittee which will develop recommendations. //2007//
/2008/ This past year the Early Intervention Service program struggled with several non-compliancy issues. Much effort was expended to bring the program into compliance and remove the federal Office of Special Education Programs (OSEP) "program at risk" category. This coupled with budgetary shortfalls prevented the program from considering expanding the class of children to be served.

Again this legislative session, there was strong vocal support from a small group of families to expand Part C services to age five. Since the regulations have not been finalized, and thoughtful consideration must be given to this option, the legislature appropriated $120,000 to conduct a formal analysis of the pros and cons of expansion, the array of services required, as well as, the type and amount of new resources needed to expand services.

In 2007 FHSD was successful in advocating for the expansion of several of its programs at the Legislature. The Early Intervention program received an emergency budget appropriation of $4.4M to cover budget shortfalls this year because of the increased number of children seen. In addition, $6.7M has been added to the Early Intervention base budget for both years of the biennium for a total annual appropriation of $19.3M.
/2010/ In order to manage the decreasing revenues for Part C services, an amendment has

been submitted to OSEP to change Part C eligibility, eliminating the environmentally at-risk classification. The state will receive approximately $2M in America Revenue Recovery Act (ARRA) funds. The funds will be used to offset the increasing caseload in Hawaii. //2010//

Because of the continuing erosion of Hawaii's Title V allocation, a decision was made in September 2006 to eliminate the Pre-school Developmental Screening Program. Legislative efforts were successful in having the five positions and operating expenses converted from Title V to state general funds. This prevents the closure of the program which was targeted for September 2007.

With strong community stakeholder support and advocacy, family planning services received an increase of $1.2M in general funds and $463,000 in TANF funds for both years of the biennium. Primary Care services received an increase of $3.8M for each year of the biennium.

The Healthy Start Program will receive $1.6M additional TANF funding to implement task force recommendations to reduce the client/worker ratio for child development and clinical services, and to expand training of the home visitors.

A total 15.5 new positions were added to the Division programs: 7 for Early Intervention Services; 5 for CSHN Branch, 1 for MCH Branch, and 2.5 for the Division.
/2010/ The Healthy Start Program's general fund budget was reduced from $11.9M to $8.4M in fiscal year 2009. The $8.4M was further reduced to $337,000 in fiscal year 2010. In fiscal year 2010, the Program will be dependent upon $337,000 in general funds, $3.0M in Tobacco Settlement funds, $1.4M in TANF funds, and a $500,000 Prevention of Child Maltreatment grant for its $5.2M budget. Funds to support the Community Health Centers were changed from general funds to a special cigarette tax fund. The Baby SAFE program was eliminated in the budget, and Family Healthy Services Division experienced other funding reductions to its family planning, perinatal, and parenting programs.//2010//

Other noteworthy MCH health bills that passed in the 2007 legislative session include:

Keiki Care Bill
Act 236 establishes a 3 year pilot program to provide health insurance for poor and low-income children who do not qualify for existing programs through several mechanisms: Children up to 300% of poverty can get free Medicaid coverage while families with higher incomes can opt for a minimum benefit health plan whose costs will be shared by the State and the state's largest insurer, HMSA.

Youth Suicide Prevention Program
Act 124 authorizes the State Department of Health to establish a statewide youth suicide early intervention and prevention two-year pilot program.

Perinatal Care
Act 147 appropriates $200,000 for FY2007-2008 to the Department of Human Services as state matching funds for a pilot perinatal clinic for women with a history of substance abuse. //2008//

/2009/ MCH-related health bills that passed in 2008:

Early Childhood Legislation
SB 2878, the Keiki First Steps bill, creates an Early Learning System allowing Hawaii to join 40 other states with a state-funded early education system. A Council will be established to develop and administer the system.
Post-Partum Care
HB 2761 allows for extension of post-partum care from 8 weeks to at least 6 months for women with Medicaid coverage.

Unattended Children in Motor Vehicles
Act 170 makes it a violation of the state traffic code to leave a child unattended in a motor vehicle under age 9 or with a minor under age 12.
Ignition Interlock
Act 171 establishes an ignition interlock law to reduce Hawaii's number of alcohol-related traffic fatalities.
Loan Repayment
Act 242 establishes a working group to develop a loan repayment program for health care professionals and stipends to physicians and dentists who work in rural or medically underserved areas.
Child Health Insurance
Act 239 extends State-funded health insurance coverage to children who are uninsured as a result of their parent/guardian being laid-off due to a company closure between February 29-September 30, 2008.//2009//

/2010/ MCH-related health bills that passed in 2009:
The focus of this legislative session was primarily on balancing the budget given decreased revenues. Three initiatives which passed legislation last year but were vetoed by the Governor again resurfaced; it is likely these measure will be vetoed once more:
1. Genetics Counselors HB 1362 requiring the DOH to license genetic counselors to ensure that accurate genetic information is passed on to the public. The DOH believes this is a responsibility of the Department of Consumer Affairs and not the DOH.
2. Sexuality Health Education SB 777 to assure that DOH contractors provide medically accurate sex education. The Department does not feel the measure is necessary as all contractors are monitored by DOH to meet standards of care.
3. Hawaii Health Authority HB 1504 to develop a comprehensive plan for universal health care coverage.

C-section HCR 215: The purpose of this measure is to promote best practices in child birth. It requires the DOH to review and assess criteria used by hospitals and physicians for elective inductions and c-sections, and to implement policies and procedures to reduce the number of both procedures. FHSD has established a committee with the assistance of March of Dimes and Healthy Mothers Healthy Babies to complete the work requested in this measure.//2010//

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). One of the objectives of PONO is to cut welfare dependency and to increase self-sufficiency. When the program was implemented in 1996, the welfare population was approximately 20,825 cases. The current population as of April 2005 is 8,236 cases. Of the current number, approximately 3,732 clients are expected to be able to enter the work force. All "able-bodied" TANF recipients experienced a 20% reduction in their cash benefits in the first year of the PONO program. Those individuals who are currently employed while in the program (about 1,737 individuals) have been able to earn back this 20% reduction, as well as an additional amount of allowed income, and are therefore in improved economic shape. An additional group of over 900 recipients are obtaining job experience with volunteer placements. However, they do not have supplemental income to offset the decrease in cash assistance and have experienced a degree of economic hardship.

The full impact of welfare reform has not yet been felt for low-income populations. The First-to-Work (FTW) Program serving parents receiving TANF has been active and services approximately 2,450 cases per month and an unduplicated number of 7,951 per year.
/2007/ The First-to-Work (FTW) Program serving parents receiving TANF has been active and services approximately 2,000 cases per month and an unduplicated number of 6,693 per year.
//2007//

Since July 1999 DHS began enforcing full family sanctions for non-compliance with federal work requirements. In December 2001 Hawaii began to terminate benefits to welfare families that exceeded the five year lifetime limit for financial assistance. Between December 2001 and June 2002, over 3,000 families lost eligibility due to the five year time limit. A disproportionate number of these families live on the island of Hawaii.
/2008/ As of March 2007 the welfare population was 6,316 cases. Of that number, approximately 2,700 clients are expected to be able to enter the work force. About 1,000 individuals are currently employed and have been able to earn back the 20% reductions in cash benefits as well as an additional amount of disregarded income for exiting the program and remaining off.
An additional group of over 900 recipients are obtaining job experience with volunteer placements. DHS will be increasing the payment standard effective July 2007 in response to the needs of these individuals and to account for the increase in the cost of living.
Between December 2001 and March 2006, over 3,410 families lost eligibility due to the five year time limit. //2008//
/2009/ The DHS TANF waiver has expired and the program is currently implementing 42 USC 601 through 619. As of March 2008 the welfare population was 5,836 cases. Of that number, approximately 1,937 clients are expected to be able to enter the work force.//2009//
/2010/ As of March 2009 the welfare population was 6,035 cases. Of that number, approximately 2,197 clients are expected to be able to enter the work force. An additional 1,196 recipients are obtaining job experience with volunteer placements. The FTW program services approximately 2,466 cases per month and an unduplicated number of 6,740 per year.//2010//

To provide greater support for Hawaii's working poor, the 2001 Legislature voted to increase the minimum wage by $1 to $6.25 by 2003 after staying the same for nine years. The increase places Hawaii eleventh in the nation for highest minimum wage. The state minimum wage is well above the federal rate of $5.15.

The 2005 Legislature passed a law to raise the minimum to $7.25 by January 2007. The increase would place Hawaii third in the nation for highest minimum wage behind Washington and Oregon.

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.
/2008/ In 2004, of those residents covered through private health insurance plans in Hawaii, 93% were covered through employment-based plans. This is up from 82% in 1990. //2008//

UNINSURED
By the late 1990s, the uninsured rate slowly increased to 8% and currently is 9.9%. Other state

health surveys report lower rates ranging from 5% to the Census high of 9.9%, approximately 60,000 to 120,000 persons without insurance. Using Census estimates, Hawaii ranks sixth in the nation for lowest uninsured, tied with New Hampshire and Vermont.

Despite the protections of the Prepaid Health Care Act, a large number of uninsured in Hawaii are working full-time and should have employer-based health care coverage. Research conducted by the Hawaii Uninsured Project (HUP) indicate about 37% of the state's uninsured adults work more than 20 hours per week.

It is generally believed that there is very high employer compliance with the law, however, there are government employees who are exempt from the law or working in family businesses. Anecdotally, researchers understand that there are also some young adults waiving health insurance benefits in exchange for higher wages. And there is an underground economy where employees accept jobs without benefits for needed income.

As a result of the HUP findings, the state Department of Labor and Industrial Relations (DLIR) began sending out investigators to ensure businesses are complying with the Prepaid Health Care Act. During 2005, DLIR will be investigating small and large firms chosen randomly by computer. O‘ahu County investigators will get a list of 60 companies per month to audit, Maui County will get 25, while Hawaii and Kauai‘i counties will get 24 and 12, respectively. /2008/ Estimates from the 2005 Current Population Survey (CPS) indicate approximately 9.6% of Hawaii's population is uninsured in 2004. A disproportionate number on uninsured reside on the islands of Hawaii, Kauai, and Maui rather than on Oahu, where the majority of the state's population lives.

Several bills were introduced this legislative session to create either a single payor system or to establish a Health Authority. None of the measures passed. //2008//
/2010/The poor economic performance and higher unemployment rates have resulted in a larger portion of the population reporting uninsured status. Community Health Centers report a 23% increase of uninsured patients served.//2010//

INSURANCE MARKET
To address rising health care costs, the Hawaii health insurance market has shifted toward managed care in both the private and public sectors. In 2002, 81% of insured Hawaii residents were covered under some form of managed care program (either a health maintenance organization or preferred provider organization), an increase of 31% since 1992.

Hawaii's inflation rate for medical care increased substantially to 8.3% in 2002, up from 1997's low of 1.1%, and twice as high compared to the national rate of 4.7%. This is in part due to the dramatic rise of retail prescription drug costs in Hawaii by 12.5% between 2001 and 2002. /2008/ Hawaii's inflation rate for medical care (as reflected by the Consumer Price Index for urban Honolulu) was 15.1% over the period from 2000-04. This was nearly double the State's overall inflation rate of 8.1% for the same period. By contrast, the U.S. inflation rate for medical care was 19%, almost double the overall rate of 9.7%.

Since 1996 Hawaii's private employer-sponsored health insurance premiums have increased less than premiums nationally. As of 2003, Hawaii premiums for single coverage averaged 13% below the nation as a whole, and family coverage averaged nearly 15% below the nation. //2008//

/2009/ A recent report by the Robert Wood Johnson foundation confirms that Hawaii health insurance premiums were among the lowest nationwide. State premiums increased by 15% for families during the first half of the decade compared to an average 30% increase nationally. Hawaii ranked 7th in the nation for its child health-care system, with high rankings in health-care cost and access for children, according to the Commonwealth Fund's 2008 report on Child Health System Performance.//2009//

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 2002 HMSA insured 32% of the Hawaii market, while Kaiser covered 14%.

/2008/ In 2004, HMSA (42%) and Kaiser (32%) continued in their market positions as the largest private health plans in the state. The other insurers 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. //2008//
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.
/2008/ The legislation permitting regulation of private health insurers lapsed in 2006, but a new bill, Act 175, was passed in the 2007 session and will be effective in 2008.//2008//

In 2002, government funded insurance represented 34.5% of residents in Hawaii: 8% Medicare, 14% for Medicaid/QUEST, and 8% covered by TRICARE that provides health care to military families and retirees.
/2008/ The number of residents in public-sponsored insurance programs has remained fairly stable from 1995 to 2004 at about 36.5% of those covered: 8% Medicare, 14% for Medicaid/QUEST, and 10% covered by TRICARE that provides health care to military families and retirees.//2008//

MEDICAID
The Hawaii QUEST demonstration project is a Medicaid waiver project administered by the Department of Human Services Med-QUEST Division which 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 300 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 in January 1996. 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.

As of December 2004 the QUEST enrollment was 157,810. Fee for service coverage (for Aged, Blind, and Disabled) was 40,200 for a total of 198,010.
/2007/ As of January 2006 the QUEST enrollment was 163,368. Fee for service coverage (for Aged, Blind, and Disabled) was 40,774 for a total of 204,142. //2007//
/2008/ As of January 2007 the QUEST enrollment was 159,039. Fee for service coverage (for Aged, Blind, and Disabled) was 40,176 for a total of 199,215. //2008//
/2009/ As of April 2008 the QUEST enrollment was 166,563. Fee for service coverage for ABD was 41,571 for a total of 208,134. //2009//
/2010/ As of April 2009 the QUEST enrollment was 181,050. The QUEST Expand Access enrollment, formerly the ABD population, was 40,229 for a total of 230,356. //2010//

Hawaii implemented the State Children's Health Insurance Program (SCHIP) as an expansion of

Medicaid and QUEST. As a result, children under 19 whose family incomes do not exceed 200% FPL are eligible under QUEST. There is no assets test. 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 effective July 1, 2000 under a state funded immigrant program.

QUEST allows participants to select medical plans from the 3 current participating providers: HMSA Kaiser and AlohaCare. As of December 2004 HMSA covered 54.5% of QUEST enrolless, Kaiser 12.9% and AlohaCare 31.4% (another 1.1% are under QUEST FFS). Not all providers are available on each island. Dental coverage is a full dental 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.
/2007/ As of January 2006 HMSA covered 55.6% of QUEST enrollees, Kaiser 12.2% and AlohaCare 30.5% (another 1.2% are under QUEST FFS). //2007//
/2008/ As of January 2007 HMSA covered 55.5% of QUEST enrollees, Kaiser 12.3% and AlohaCare 31.0% (another 1.2% are under QUEST FFS). Using a competitive bidding process, Med-QUEST was able to add a new health plan and secure expanded services for enrollees in 2007. Summerlin Life is a new health plan option for MedQuest clients. The 4 QUEST health plans will offer additional services for disease management and some plans will offer health promotion programs for enrollees. Med-QUEST will also be implementing a new quality assurance program. Plans will receive financial incentives for meeting quality performance standards and be assessed penalties if they fail to meet baseline requirements. //2008//
/2009/ As of April 2008 HMSA covered 49.9% of QUEST enrollees, Kaiser 11.7%, AlohaCare 35.9%, and Summerlin 1.0% (another 1.5% are under QUEST FFS). //2009//
/2010/ As of April 2009 HMSA covered 50.6% of QUEST enrollees, Kaiser 11.6%, AlohaCare 35.3%, and Summerlin 0.9% (another 1.6% are under QUEST FFS). //2010//

Initially, QUEST was to incorporate all existing Medicaid recipients, including the aged, blind, and disabled (ABD) population through Phase II of the project in 1997. The State currently has an application in with the Centers for Medicare and Medicaid Services (CMS) to move the ABD population to managed care. The anticipated date for enrollment into managed care plans is July 1, 2007.
/2007/ The anticipated date for enrollment into managed care plans is July 1, 2008. //2007//
/2009/ Starting November 2008, the ABD population will transition into a managed care system through the new QUEST Expanded Access (QExA) Medicaid program. QExA is designed to improve health outcomes and assure service quality through strict reporting requirements that will enable DHS to monitor the performance of health plans to ensure that clients receive timely access to needed care.

In February, DHS awarded the 3-year $1.5 billion QExA contracts to national insurers UnitedHealth Group and WellCare Health. AlohaCare, a Hawaii non-profit health plan founded by Hawaii's community health centers, failed to receive the bid and filed an administrative appeal and federal lawsuit challenging the award. Issues raised included flaws with the procurement process, improper licensing of the new contractor, and whether the state can force 2,500 disabled children into managed care. Both the appeal and lawsuit have been dismissed, however, the Hawaii Coalition for Health, a health education organization, filed another lawsuit in June.

DHS has applied to CMS to postpone implementation of the contract until February 2009.

Overseeing this transition is the new Medicaid Director, Dr. Kenneth Fink, MD, MPH. He is the former Chief Medical Officer for Centers for Medicare & Medicaid Services (CMS), Region 10. Prior to that, Dr. Fink served as the Director of the Evidence-Based Practice Centers for the Agency for Health Care Research and Quality at CMS.
//2009//

Hawaii's waiver program expired on 30 June 2005. DHS was given a one-month extension while

the new waiver application is being reviewed. The application for renewal and expansion of the current Medicaid QUEST waiver program was submitted with extensive input from the community and providers. All current QUEST eligibility groups would continue and, depending on cost projections and available resources DHS plans to expand services by:

*Extending children's coverage under the State Children's Health Insurance Program (CHIP) from the current family income level of 200% of the federal poverty level (FPL) to at least 225% FPL.

*Eliminating a requirement that children must be enrolled in QUEST to continue in QUEST-Net (a program developed for people who no longer qualify for QUEST with income levels up to 300% FPL). This ensures that all children from families with incomes at or below 300% FPL have access to the full QUEST benefit package with no cost to families up to at least 225% FPL and with a reasonable premium for families with income up to 300% FPL.

*Providing QUEST coverage for all children in the state's child welfare system. The few who are not otherwise eligible will be covered by a state-only benefit. These children will receive additional services through the QUEST plans, including direct access to a specially trained health care provider to identify and handle child abuse and a complete examination and assessment within an established number of days of entering the system.

*Piloting a Health Insurance Flexibility and Accountability (HIFA) program for employed individuals leaving TANF. Parents will be offered COBRA-like premium assistance for an additional year after their mandatory Medicaid coverage ends.

The goal is to increase access to high quality health care, reduce the number of uninsured children, and preserve Hawaii's generous federal matching funds at sustainable levels.
/2007/ The Medicaid QUEST waiver was approved on January 31, 2006. DHS will expand services by:

* Extending children's coverage under the State Children's Health Insurance Program (CHIP) from the current family income level of 200% of the federal poverty level (FPL) to at least 300% FPL.

* Eliminating a requirement that children must be enrolled in QUEST to continue in QUEST-Net (a program developed mainly for people who no longer qualify for QUEST with income levels up to 300% FPL). This ensures that all children from families with incomes at or below 300% FPL have access to the full QUEST benefit package with no cost to families up to 250% FPL and with a reasonable premium for families with income from 251-300% FPL. Premiums for QUEST-Net will be reduced from $60 a month to $15-$30, depending on income.

The QUEST expansion will also target more low-income adults who earn $910 a month. It is anticipated that 29,000 more people will qualify for QUEST under the new waiver: 20,000 low-income adults and 9,000 children. The waiver also allows the state to continue to make direct payments to hospitals to offset the costs of caring for the uninsured.//2007//
/2008/ The QUEST waiver renewal will use more than $100 million in new Federal funds to cover the majority of healthcare costs of uninsured adults and children over a 6-year period. Up to 20,000 uninsured adults are now able to receive Medicaid health insurance through the new QUEST-ACE (Adult Coverage Expansion) launched by DHS in March 2007. This program helps adults who could not sign up for QUEST due to the statewide enrollment cap imposed in 1996. QUEST-ACE provides insurance for men and women ages 19 through 64 without dependent children whose annual earnings are at or below the FPL.
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 State previously only paid for emergency dental services, such as tooth extractions. //2008//
/2009/ In January 2008, the state's 3-year pilot Keiki Care plan went into effect providing free health insurance for children up to 300% FPL. The bill covers premium payments for children in

Med-QUEST's programs whose household incomes are between 251-300% FPL. The cost for the program will be monitored to determine sustainability. //2009//

Efforts to achieve universal coverage continue through other projects. The DOH has partnered with the HMSA Foundation to address the issue of the uninsured. Hawaii's Uninsured Project conducted a conference this past year to identify the issues surrounding the uninsured and to develop appropriate strategies.

In January 2004 Hawaii was awarded $3.2 million in RWJ Foundation funds for a three year project to implement universal health care coverage. Work continued this year in partnership with the University of Hawaii, Social Science Research Institute and Hawaii Institute of Public Affairs to define the uninsured, frame their issues, explore solutions with stakeholders, and conduct economic modeling of the various options.

The Hawaii Uninsured Project published On Common Ground in 2002 which outlined the issues around the uninsured: who are they and what are their issues. In January 2005, HUP published Pathways to Coverage which outlined strategies endorsed by a broad cross-section of stakeholders to expand coverage further. The Department of Human Services has shortened its application form and has implemented passive renewal which has resulted in increased enrollment. DHS has also extended QUEST coverage to pregnant immigrant women.

/2008/ Both the State Planning Grant and the RWJ Foundation grant terminated in 2006. Over the past 5 years the project heightened public and policy makers' awareness about the uninsured and their impact on the health care delivery system. In this period there has been successful expansion of the State Child Health Insurance Program (SCHIP), a slight increase of Medicaid coverage for the adult population, and application simplification. The private sector has increased its offerings to the part-time and self employed. General fund subsidies for the community health centers have increased substantially. There has been a reaffirmation that Hawaii's Prepaid Health Care Act has served to insure the majority of the population. There has not been a systemic revision of Hawaii's health care system as originally envisioned.
Despite this, for the first time in the past 10 years, Hawaii has witnessed a slight reduction in the adult uninsured rate, and a substantial reduction in the uninsured rates for children. The Hawaii Health Information Corporation has reported for the first time lower rates of uninsured children being treated in emergency rooms.//2008//

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 200% of the Federal Poverty Level (FPL) for Hawaii. There is no waiting period for SCHIP eligibility. As of December 2004, 13,719 children were enrolled in SCHIP.
/2008/ As of January 2007 the SCHIP enrollment was 16,885.//2008//
/2009/ As of April 2008, the SCHIP enrollment was 18,675.//2009//
/2010/ As of April 2009, the SCHIP enrollment was 20,720.//2010//

Effective July 1, 2000, legal immigrants, refugees, and those born in the Marshall Islands, Federated States of Micronesia and Palau were eligible for QUEST-like health coverage under a state-funded immigrant children's program which has the same eligibility requirements as QUEST. As of December 2004, 2,855 immigrant children were enrolled.
/2008/ As of January 2007 the immigrant child enrollment was 3,162.//2008//

/2009/ As of April 2008, the immigrant child enrollment was 3,395.//2009//
/2010/ As of April 2008, the immigrant child enrollment was 3,789.//2010//

STATE DEPARTMENT OF HEALTH: CURRENT PRIORITIES & INITIATIVES
The 2005 Department of Health Annual Report identifies four initiatives for continued focus:
1. Develop sustainable solutions that ensure the provision of quality of care for the elderly;
2. Improve Hawaii's mental health system.
3. Advocate for the adoption of healthy lifestyles to reduce the incidence and morbidity of chronic disease;
4. Public Health emergency preparedness.

The promotion of the ten essential public health functions is still a cornerstone priority of the Department. Family Health Services Division programs and activities are in alignment with three of the six stated goals of the Department of Health:
1. Promote and encourage healthy and safe behaviors.
2. Assure equitable, accessible health and support services.
3. Attain a culture of organizational excellence that provides effective public health programs and leadership for the State of Hawaii.
/2008/ DOH Director Fukino identified the following priorities for the Department of Health for the next 4 years:
1. Assuring a viable and sustainable mental health system of care.
2. Disaster readiness and response.
3. Assuring access to quality health care, including the development of an EMS Trauma System Plan and the expansion of tele-health.
4. Assuring a continuum of quality services for the care of seniors and disabled individuals.
5. Improving departmental processes, reflective of current business standards.
6. Primary Prevention: the promotion of good nutrition, exercise, and smoking cessation.//2008//

An attachment is included in this section.

B. Agency Capacity

Public Health in Hawaii, including the Title V program, continues to transition from direct services to the core public health functions aimed at improving the health of the entire population consistent with national health objectives. The landmark 1988 Institute of Medicine Report, The Future of Public Health, characterized these core functions as assessment, policy development and assurance.

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. Hawaii's MCH 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 the complex changes occurring in health care financing and delivery.

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). The mission of FHSD is "to assure the availability of and access to preventive and protective health services for individuals and families by providing leadership in collaboration with communities and public-

private partners."

The Division goals are:
1. Pregnancy/conception shall occur by choice and under circumstances of lowest risk.

2. Every pregnant woman will utilize appropriate services and engage in healthy behaviors to optimize 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, family-centered, culturally competent system of care.

6. FHSD shall have the necessary infrastructure to support the implementation of the core public health functions.

PROGRAM INITIATIVES
The 2005 Session of the Hawaii State Legislature proved to be tumultuous for FHSD early intervention programs. While the Legislature wanted to ensure adequate funding for both the Healthy Start and Early Intervention programs, they did not reauthorize use of $5 million in Tobacco Settlement funds for this purpose. Early Intervention Special Fund dollars of $2 million, generated from Medicaid reimbursements for EI services, were earmarked for Healthy Start for a net decline of $3 million from current levels. Mandated services under IDEA Part C to infants and children up to three years of age will receive at least $2.5 million from the EI special fund under the authorization for State FY06. It is anticipated that an emergency appropriation for additional funds for EI mandated services will be needed to meet the needs for FY06. The Healthy Start program was under intense scrutiny and anticipates substantial retooling over the next two years.

/2008/ In the 2006 legislative session an additional emergency budget appropriation was requested and approved for the Early Intervention services. To cover the reduction in Tobacco Settlement Funds for Healthy Start and to provide home visitation services to child welfare families, $3.2M of TANF dollars was transferred to the Department of Health.

With the increasing enrollment of Early Intervention services it was again necessary to request an emergency budget appropriation in the 2007 legislative session. An additional $4.4M was added to the current budget to meet cost overruns.The 2008 fiscal year will see a $6.7M increase to the base budget for Early Intervention for a total program budget of $19.3M.

The Healthy Start program completed a task force report to the legislature regarding its efforts to improve program performance. An additional $1.6M of TANF dollars has been appropriated for additional training and to reduce client/staff ratios for the clinical specialist and child development specialist which strengthens the home visitation component of the program.

Family Planning services have been largely dependent upon the Division's Title X appropriation since the general fund budget was cut in half more than ten years ago. Through community advocacy, a legislative task force report recommended a substantial increase for the family planning program. As a result, $1.2M of general funds and $463,000 of TANF dollars were added to the Division's base budget. //2008//

FHSD has worked vigorously to gather timely, reliable data regarding the health of our state's families to assure that needs are met by effective communication to the state legislature and by obtaining additional federal and private resources to supplement available state funds. Statistics

show Hawaii residents enjoy relatively good health compared to national standards; however, significant disparities exist between geographic regions within the state and between different ethnic groups. FHSD has accepted responsibility for identifying and addressing these disparities as they relate to the health of our women, children, and families.

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 tried to enhance program efficiency and effectiveness through several initiatives.

FHSD is enhancing 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.

/2008/The Department has placed a priority on program responsiveness to the needs of the Native Hawaiian and Pacific Island populations. The Division through a "mini data" grant from the Association of Maternal and Child Health Programs will conduct a training for program managers and data staff on the topic of culturally competent data collection. The two day training is scheduled for June 2007 and will educate the staff about acceptable behaviors and approaches to soliciting information from Native Hawaiians and Pacific Islanders. The issues of qualitative data design and analysis will also be covered in the training sessions. //2008//

/2007/ In 2006 the Primary Care Office grant and planning position was transferred to the Department of Health Office of Planning. A portion of the grant funding was retained with the Title V program to continue the administration of state-funded primary care service contracts for the uninsured. //2007//.

/2009/ In 2008 the Primary Care Office (PCO) grant and planning position was transferred back to the Title V agency. A new position for a Registered Nurse was established at the Division level to manage the primary care program. The RN will oversee the PCO grant and monitor the state-funded primary care service contracts for the uninsured (which totaled $3.5 million in 2009). The position was approved by the 2007 Legislature //2009//

/2010/The primary care nurse position was filled effective February 2009, and she has begun her quality assurance efforts with the Community Health Centers.//2010//

The Division has contracted with a private firm to develop its Early Intervention Data Management System. Parts of the system are operating to improve clients tracking, program reporting and billing.

/2008/ The client tracking system for Healthy Start as been operational for a few years. Current efforts are focusing on modifying the system to meet Part C requirements and to integrate billing functions across both Health Start and the Early Intervention programs. //2008//

Data linkage initiatives between newborn screening programs and vital statistics are completed. Data is routinely linked. New initiatives include linkage with WIC and birth certificates. Discussions are underway with Medicaid to explore procedures for data linkage with birth certificates.

/2009/ Routine data linkage between WIC and birth certificates was established in December 2007 with the DOH Office of Health Status Monitoring (the vital statistics office). Discussions with the new Medicaid Director will be initiated to discuss possible linkage with birth certificates. Also linkage between hospital discharge data and birth certificates is also being explored.//2009//

/2010/ FHSD continues to work to secure the Medicaid data. In the interim, FHSD has access to Hawaii Health Information Corporation dataset of statewide hospital and emergency room data; allowing FHSD to conduct analysis on various health indicators by Medicaid status.//2010//

WIC's statewide automated information system provides important program data for this large at-risk population. Linkage with vital statistics, Medicaid and other datasets is being explored and the WIC dataset is scheduled to be placed in the electronic data warehouse in late 2005. Data linkage will help strengthen collaboration between WIC and other programs in childhood immunizations, breastfeeding, oral health and assuring access to health and social services for low-income children and mothers. In July 2005, WIC services on the island of Molokai will be transferred from State staff via contract to a Native Hawaiian Health Care System provider.

/2007/ WIC's statewide dataset was placed in the data warehouse in FY2006. State Nutrition Assistant and Nutrition Aid classes were established in FY2006 retroactive to November 2004, paving the way to transition from a registered dietitian intensive model to one using more trained paraprofessionals. WIC plans to implement some Best Practices identified in FY 2006 to increase program efficiency. //2007//

/2008/ WIC will offer on-line training for paraprofessionals through the University of Alaska Anchorage. Two additional breastfeeding peer counselors were trained. Staff will be trained on participant-centered education. A pilot project to upgrade two nodes on the wide area network and consolidate databases should be completed by December 2007. //2008//

/2009/ A statewide breastfeeding coordinator started in June 2007 and supports two existing peer counselors and six more in training. Statewide breastfeeding training was provided. On-site mentoring on participant-centered education and additional training was provided. Twenty paraprofessionals are enrolled in on-line training to increase capacity. Although network upgrade is on track, system responsiveness was unacceptable in the pilot database consolidation project .//2009//

/2010/ Five WIC paraprofessionals have passed the on-line training to date; more are expected to become certified professional authorities (CPA) by October 2009. A Big Island agency is training home visitors to be breastfeeding peer counselors (BFPC). WIC continues to build on Participant-centered education (PCE) trainings in 2007 and 2008 by fine-tuning mentoring efforts to effect clients' behavior change. Routine data linkage between WIC client records and birth certificates is used to address data quality issues. The consolidation of WIC databases was not feasible. WIC now plans a feasibility study to replace the 10-year old information system. //2010//

FHSD is working to improve collaboration both within the Division, within DOH, and across State departments to assure efficient use of ever limited funding resources.

MCH Branch is administering surplus TANF funding to contract with agencies to promote teen pregnancy prevention efforts. Funds have been used to hire a program specialist to manage program contracts.

The Division 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. In addition four staff have graduated from the University of Hawaii Maternal and Child Health Certificate program, another three staff are currently enrolled in the program.

/2008/ Title V staff continue to enroll in courses offered by the MCH Certificate program.

The Division has proposed a major reorganization to its current structure to better align its programs with federal mandates and funding streams. The current Children with Special Health Needs Branch and the Maternal and Child Health Branch are being reconfigured to become the Early Intervention Services Branch, which will house the Part C- I.D.E.A. initiative and the Family and Child Health Branch which will house all of the Title V programs including Children with Special Health Needs. There are no proposed changes to the WIC Services Branch.

In addition there is a proposed change in the Division title, from Family Health Services to Family Health Systems Division to reflect the role of pubic health in health care systems development. There is also a proposal to create a Surveillance, Epidemiology and Evaluation unit at the Division level, as well as centralizing the billing function at the Division level. //2008//

/2009/ The reorganization plan is still pending administrative review. //2009//

/2010/ With the primary emphasis on reduction in service and budget cuts, all proposed reorganizations have been put on hold. //2010//

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, and research. The Director's Office oversees coordination for the Office of Primary Care, Title V, the State Systems Development Initiative, and the Data Utilization and Enhancement (DUE) grants. The attached chart shows the staff and functions under the Director. The seven positions funded with federal Title V funds are identified on the chart in addition to the Branch Chief for CSHN.

/2007/ In December 2005, the Nurse Consultant position in the Director's Office was vacated through retirement and will not be replaced. The position is being converted into a temporary position to hire an epidemiologist. The Primary Care Office grant and planner position have been transferred to the DOH Planning Office. The state-funded primary care service contracts for the uninsured will continue to be administered by the Director's office.

/2008/ With the retirement of the incumbent, the Division has made the decision to abolish the Nurse Consultant position. As position salaries increase over time, it becomes necessary for the Division to either abolish or seek other funding streams to live within our Title V allocation. The Pre-school Developmental Screening program with its 5 positions has been switched off of Title V to state general funds. Four administrative positions within the Children with Special Health Needs Branch have been switched to the Part C- I.D.E.A. appropriation. //2008//

The Early Childhood Comprehensive Systems (ECCS) grant has been moved from MCH Branch to Division level. A new Fetal Alcohol Spectrum Disorder (FASD) position with approved funding from the 2006 Legislature will be established at the Division level. A FASD coordinator will be hired later in 2006. //2007//

/2009/ The ECCS and FASD grants were placed at the Division level due to the Division focus on systems development and planning. Work on early childhood systems helped spur Family Health Services Division's reorganization to better align Division programs to improve service delivery to young children and their families. //2009//

/2008/ The Division is now in the process of hiring the new FASD coordinator. Also, Don Hayes, M.D., M.PH. will be joining the Family Health Services Division as the new Title V funded CDC-assigned epidemiologist on July 9, 2007. //2008//

/2009/ The new FASD Coordinator was hired in November 2007. Don Hayes is now serving as the CDC-assigned epidemiologist. A new Primary Care Nurse will start in July and oversee the Primary Care Office grant and planner. Two Information Technology staff were also hired this year to assist with Medicaid reimbursements for Early Intervention programs and to provide general user support for the Division staff. //2009//

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 has 185 FTE time employees, of which 19 are Title V funded. Programs include Early Intervention, Preschool Developmental Screening (PDSP), Newborn Hearing Screening, Newborn Metabolic Screening, Children with Special Health Needs, 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.

/2007/ The number of employees who are Title V funded is now 18.5 FTE, with a clerk-typist position decreasing from 1.0 to 0.5 FTE. //2007//

/2008/ There are now 12.5 FTE Title V funded positions, with deletion of an account clerk position and switching 5 PDSP positions to State funding. CSHNB has 202.75 FTE employees, with new positions for Children with Special Health Needs, PDSP, Early Intervention, and Genetics programs and projects.//2008//

/2010/CSHNB now has 197.25 FTE authorized positions. Title V funded positions decreased due to a vacant Children & Youth (C&Y) Specialist position that will not be filled. The 2009 State Legislature deleted 7.0 FTE vacant state-funded positions (3 C&Y Specialists, physical therapist, 2 social workers, and paramedical assistant) in the Early Intervention Section. There may be further changes as the state government addresses the budget deficit.//2010//

MATERNAL AND CHILD HEALTH BRANCH (MCHB)
The Maternal and Child Health Branch, comprised of approximately 50 FTEs, 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. Eighteen of these positions are Title V funded, 22 are state funded and 10 are funded by other federal sources. The Branch is divided into four major programmatic areas: Women's Health Section; Children and Youth Wellness Section; Family and Community Support Section and an Administrative Section with fiscal and data units. 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 working collaboratively with community partners support core public health functions in the State. These 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.
/2010/ MCHB FTEs are 54.5, 16.5 of these positions are Title V funded, 20 are state funded and 18 are funded by other federal sources.//2010//

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 providing nutritional counseling and food assistance for low-income pregnant and post-partum women and children up to age 5. During F FY 2003 & 2004, Hawaii WIC served an average of 32,788 and 33,221 individuals a month, respectively, drawing closer its goal of providing nutritional services to an estimated 41,000 eligible persons statewide. Approximately 50% of the caseload is children age 1-5 years, 25% are women and 25% are infants. With 115.5 FTEs located throughout the state, the program is designed to help 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 services are provided through purchase-of-service (POS) and state-run agencies. WIC contracts with six Community Health Centers, one Native Hawaiian Health Care Center and one hospital to provide services, resulting in greater integrated health service delivery. Along with income eligibility (185% of poverty level), all participants must be considered nutritionally "at-risk."

/2007/ During FFY 2005, Hawaii WIC served an average of 32,586 individuals a month. State FTEs were decreased to 113.5 in FY 2006. WIC enrollment in the first trimester increased from 18.8% to 30.4% from 2004 to 2005. //2007//

/2008/ During FFY 2006, Hawaii WIC served an average of 32,075 individuals each month. New contracts with private providers effective FFY2008 include a new comprehensive health center on Lanai. WIC will transition infant formulas due to a new rebate contract effective FFY2008. New food packages including fruits and vegetables will be developed after USDA guidelines are released in September 2007. //2008//

/2009/ During FFY 2007, Hawaii WIC served an average of 32,612 individuals each month. Due to rising food prices, the Program requires purchase of least expensive milk effective February 2008. The transition from Mead Johnson to Ross contract infant formulas in October 2007 was relatively smooth. New food packages including fruits and vegetables, less milk and cheese, less juice, more whole grains will be implemented October 2009. //2009//

/2010/ During FFY 2008, Hawaii WIC served an average of 34,050 individuals each month. The Program controlled food costs further by dropping bottled juice in August 2009 (except for families with limited cooking and storage). A new contractor will handle special formula and medical foods from September 2009. WIC staff were introduced to the new food packages at a biennial conference in May 2009, with vendor and client education to follow. A "Healthy Habits for Life" kit will be distributed to families to reinforce key nutrition and physical activity messages. //2010//

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), WIC, Maternal and Child health. They also coordinate FHSD programs in family planning, perinatal services and primary care. Each office may also administer grants specifically designed to target the needs of their rural island communities.

/2009/ Coordinators have also been active in DHO initiatives such as School Flu Clinics and disaster preparedness activities. //2009//

/2010/ Coordinators and other division staff have been involved with the response to the H1N1 outbreak and investigation. //2010//

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 Oʻahu. On Oʻahu, 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 functions on the Island of Hawaii are handled by a Nurse Manager for Special Services. Maylyn Tallett provides DHO administrative supervision and support for Title V programs, which include Children With Special Health Needs (2 Social Workers, half-time Clerk Typist) and Early Intervention Section (8 Social Workers, 1 Quality Assurance Specialist, 1 Occupational Therapist Program Manager, 1 Occupational Therapist, 1 Physical Therapist, 1 Speech Language Therapist, 1 Special Education Teacher, 2 Paramedical Assistants, 1 Data Clerk and half-time Clerk Typist) and a Clerk Steno. The supervision of the Malama A Ho'opili Pono Project and WIC are managed by individual program supervisors.

/2008/ As of September 2006, the FHSD Coordinator has taken on the responsibilities of providing administrative supervision for the Malama A Ho'opili Pono Project (federal Healthy Start Perinatal Health Disparities Project) staff which includes, 2 Registered Nurses, 1 Social Worker, and a Clerk Typist. The supervision of the WIC program is managed by another program supervisor. //2008//

/2010/ Early Intervention Section -- social worker staff has decreased to 3 due to movement of Social work positions to purchase of service programs. Malama A Ho'opili Pono Project has been renamed The Big Island Perinatal Health Disparities Project with Malama Perinatal Program (MPP) direct outreach services contracted to Family Support Services of West Hawaii and consortia leadership contracted out to Hui Malama Ola Na ʻOiwi. Maternal and Child Support Services (MCSS) staff continue to be actively involved in the BIPHD Project with 4 local area perinatal consortia and program monitoring activities for MPP. MCSS staff are engaged in Child Death Reviews and in May attended a local Domestic Violence Fatality Review.//2010//

Other related MCH duties include facilitating the Hawaii & Tri-County Dental Task Force meetings and Community Health Centers -- Oral Health Issues meetings. The Nurse Manager represents the DHO at the following meetings, the Hawaii Island Tobacco Free Partnership Coalition, Keiki Injury Prevention Coalition, Big Island Good Beginnings Alliance, East Hawaii Friends of Foster Families, Hawaii County Behavioral Health, Primary Care Roundtable and the Breast and Cervical Cancer Control Programs. Additional responsibilities include the management of special projects, such as providing support to the Hawaii Island Anti-Bully Coalition to provide awareness & education to the community about bullying behavior utilizing the Domestic Violence Prevention Special Fund. Also, the Nurse Manager is currently assisting the Community Health Centers to create a sustainable network of agencies to provide dental services to children throughout the entire island. Furthermore, ongoing collaboration with the Department of Education to form a network with the Early Intervention staff and private agencies to provide assistance to children eligible for IDEA services, has been positive and allowed for improved transitions.

/2007/ The Hawaii island FHSD Coordinator special project work no longer includes the Anti-Bullying Coalition and the dental service project with the Community Health Centers. Collaboration with the Department of Education, EI staff, and private agencies continues to provide assistance to children eligible for IDEA services. //2007//

/2008/ The FHSD Coordinator no longer is working directly with the Community Health Centers to provide dental services for children. But, continues to facilitate the Hawaii Island & Tri-County Dental Health Task Force meetings. Community partners include the Hamakua Health Center, West Hawaii Community Health Center, Hui Malama Ola Na Oiwi, Keaau Family Health Center, Mobile Dental Van Project, and community volunteers. //2008//

/2010/Due to program and administrative demands, the Hawaii Island FHSD Coordinator has not actively participated in meetings with the Hawaii Island Tobacco Free Partnership Coalition, Keiki Injury Prevention Coalition, Big Island Good Beginnings Alliance, Hawaii County Behavioral Health and the Breast and Cervical Cancer Control Programs. Other DOH representatives have been assigned to participate in these meetings. Focus remains at maintaining program operations for the following Family Health Services Division, Hawaii District Health Office programs: Kona Early Childhood Services, Children with Special Health Needs, Maternal and Child Support Services and Early Intervention. Facilitation of meetings with the Hawaii Island Dental Health Task Force and the Tri-County Dental Task Force continues on a regular basis. Ongoing collaboration and partnerships with DOE, private organizations, Community Health Centers and local physicians continue to be a priority to help with seamless transitions of our clients and families in receiving appropriate care and services.//2010//

MAUI COUNTY (Includes islands Maui, Molokaʻi & Lanaʻi)
The FHSD programs in Maui Tri-Isle County are supervised by a registered nurse, Jeny R. Bissell, who is responsible for the administrative supervision of all FHSD programs and employees, which includes WIC (2 nutritionists, 6 paramedical assistants, 2 clerks, 1 clerk-typist), Early Intervention (5 social workers), CSHN (1 social worker), MCH (1 registered nurse), and a clerk steno. Substantial time is devoted toward building a coordinated system of services, in collaboration with the Department of Education and Part C Agencies for children eligible for IDEA services. Additional duties include special projects related to Title V, FHSD, and/or the Maui District Health Office such as the Injury Prevention Project and Primary Violence Prevention Project.

/2007/ WIC personnel include 2 Nutrition Assistants and Early Intervention has added 2 social workers. //2007//

/2008/ WIC Paramedical Assistants (PMA) were reclassified to 2 Nutrition Assistants and 3 Nutrition Aides. Maui WIC Program lost a full time Public Health Nutritionist IV in May 2007. The position will be announced and filled. Maui Early Intervention Program (MEIP) lost a full time Children and Youth Quality Assurance Specialist IV in May 2007 and Social Worker III in March 2007. Both positions will be announced and filled. One MEIP SW III position was reclassified to Clinical Psychology Assistant IV to provide psychological and behavioral support services to infants and toddlers with special health care needs and their families. Two MEIP SW III's were transferred to Oahu Early Intervention Section in 2007.

The Maui MCH Coordinator retired in November 2006 and was replaced in March 2007. The Injury and Primary Prevention Projects were completed in March 2007 and February 2006, respectively. The Maui FHSD Coordinator is also a member of the Maui Domestic Violence Task Force, Child Safety Collaborative Committee, the Maui Tri-Isle County Committee on Child Maltreatment Prevention and Maui Training Collaborative Committee. //2008//

Duties and supervision responsibilities for the position have been changed slightly. While each program will be directed by the Branch supervisor on program related issues, the FHSD

Coordinator will work closely with the community to assure effectiveness of Title V programs. She will also identify unmet needs of the Title V target population and, through partnerships with other agencies, design special programs and projects to address these issues. Currently, examples of such special programs for Maui include, oral health, lead, mercury, tobacco, alcohol and substance abuse. Additional duties include special projects related to Title V, FHSD, and/or the Maui District Health Office such as the Injury Prevention Project, Primary Violence Prevention Project and Tobacco Prevention and Outreach Project.

Other duties for the FHSD Coordinator include participation in the Maui State and County Agencies Servicing Children, Maui Part C-IDEA Collaboration Agencies, Maui Children Welfare Services (CWS) Citizen Review Panel, Early Head Start and Head Start Health Advisory Council, Sequenced Transition to Education in the Public Schools (STEPS) Interagency Team, Maui Children Justice Center Committee, Title IV B Maui Regional Planning Group, Primary Care Roundtable and Maui Homeless Alliance. Other duties include serving as an alternative representative to the Maui Maternal and Child Health Coordinator in the Pediatric and Women Board Committee, Maui Tobacco Free Partnership, Children Welfare Advisory Council and Coalition to End Abuse. Additional duties include serving as an alternative representative to the Maui District Health Officer in the Tri-Isle Dental Alliance and MEO BEST Advisory Council.

/2007/ The Maui FHSD Coordinator also sits on the Maui Children Justice Center Committee (also known as Children Justice Center Task Force). //2007//

/2009/ Personnel updates include several vacancies: Early Intervention C & Y/Quality Assurance Specialist; WIC Public Health Nutritionist, aide, and clerk; and a CSHN Social Worker position. A position for an Early Intervention Clinical Psychology Assistant is being established and is pending administrative approval. The 2 WIC Nutrition Aides started the P-CPA Certification training and anticipated completion date Februay 2009.

The Maui MCH Coordinator continues to chair and facilitate the CDR process in the County of Maui. She continues to promote the Title V priorities through education and outreach to various community based coalitions and advisory groups. She is the chair of the Maui Women's Health Committee that is tasked to promote awareness and education on women's health issues and ways to maintain health and wellness.

The Coordinator assisted with the FASD training for Maui. She is part of the planning committee for the 2008 Perinatal Summit scheduled for October. She continues to promote the Hawaii State Injury Prevention Plan in the County of Maui by actively participating in the state Injury Prevention Advisory Committee and attended the 2008 Johns Hopkins Summer Institute Training on Injury Prevention in Baltimore, Maryland. Ms. Bissell is overseeing the Maui Fall Prevention Project for Frail and Well Elderly and is an alternate member to the Maui Oral Health Task Force. She is a member of the Maui Filipino Working Group/Tri-Isle Resource Conservation and Development that is tasked to promote social justice to Filipinos in Hawaii and facilitate trainings on Filipino cultural competency to health and human services providers. She is also a member of the Maui Interpreters' Hui that is tasked to provide training to language interpreters and service providers to increase access and utilization of preventive and protective health services for individuals and families with limited English proficiency.//2009//

/2010/Personnel updates include several vacancies which are in the process of interviewing: WIC Public Health Nutrtionist Local Agency Coordinator, Public Health Nutritionist III, WIC Office Assistant II, Hana WIC Nutrition Aide. Several positions are also frozen or may be deleted due to budget restrictions (CSHN SW/HSP IV, EIS C & Y Quality Assurance Specialist, EIS HSP/SW. All 4 WIC Nutrition Assistants are CPAs. A FHSS Office Assistant III and CSHNP HSP/SW IV were hired in January 2009.

Maui MCH Coordinator and FHSD Supervisor/Coordinator participated in the first Maui DV Fatality Review in April 2009. The Maui MCH Coordinator continues to chair the CDR

process for Maui County and is coordinating the first combined CDR and DV Fatality Review for August 2009.

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). The FHSD Supervisor/Coordinator supervised the 4th Fall Prevention Project for frail and well elderly.

The FHSD Supervisor/Coordinator are 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.//2010//

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 nutritionist, 2 PMA, 1 clerk-typist, 1 clerk), Maternal & Child Health (1 nurse coordinator), and Early Intervention Section (3 social workers). The Program Manager is also responsible for several Title V service contracts and grant funded initiatives on the island that includes Malama Kauai Project, Malama Smoking Cessation Programs. Malama (which means to "protect" or "to care for" in Hawaiian) programs address the needs of high risk pregnant women. 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 the Kauai Keiki Injury Prevention Coalition.

//2008// The two WIC PMAs were reclassified to nutrition aid positions. The FHSD Coordinator is also responsible for managing the Kauai 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). //2008//

/2009/ As of May 1, WIC added another nutrition aid position. The Coordinator now 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 the services to all sexual assault victims across the state are responsive, effective, and forensically sound. //2009//

/2010/ WIC PMA positions were reclassified to nutritional aids. A new WIC nutritional aid was hired for a total of 3. There is only 1 clerk typist for WIC. Additional collaborative

initiatives on Kauai include SNAPed (Nutrition and Physical education) a food stamp nutrition education project.//2010//

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 200 purchase of service contracts, memorandum of agreements and fee for service contracts were executed in state fiscal year 2004 totaling nearly $51 million to deliver direct, enabling, population based and infrastructure building services to the MCH population.

All vendors with FHSD contracts to provide direct and enabling services must report on uniform performance measures that assure the quality of care. Contracts are monitored by FHSD program staff by area of expertise. Most contracts are for the provision of direct and enabling services. A smaller portion of the contracts include technical assistance with data capacity, epidemiological analysis and research, evaluation services, community development, and auditing services.

An attachment is included in this section.

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 Children with Special Health Needs Branch is part of FHSD.

The 2001 election of Governor Linda Lingle has resulted in the appointment of all new state department directors and deputy directors. Dr. Chiyome Fukino, M.D. is the current Director of Health, with Dr. Linda Rosen, (formerly the FHSD Medical Director) as the Health Resources Deputy; Michelle R. Hill is Behavioral Health Deputy; Ms. Susan Jackson is the Administrative Deputy, and Laurence K. Lau, Esq. is the Environmental Health Deputy.

/2007/ In 2006 Dr. Rosen was appointed to head the Emergency Medical Services System Branch. She is also currently serving as DOH Deputy until a replacement can be found. //2007//

/2008/ Dr. Morgan Barrett, M.D., M.P.H. was appointed the new Deputy for the Health Resources Administration in September 2006. Prior to his appointment as Deputy Director for HRA, Dr. Barrett was Clinical Assistant Professor of Radiation Oncology at the University of Wisconsin School of Medicine and Public Health and practiced clinical Radiation Oncology for 10 years.

Dr. Fukino was reappointed in 2007 to serve another four year term as DOH Director. Along with Dr. Barrett, all other DOH Deputies will continue in office: Michelle R. Hill as Behavioral Health Deputy; Ms. Susan Jackson as the Administrative Deputy, and Laurence K. Lau, Esq. as the Environmental Health Deputy. //2008//

/2009/ A few changes were made to the DOH organizational chart, although none of the changes effect the Title V agency. An updated chart is attached. //2009//

/2010/ Dr. Morgan Barrett, M.D., M.P.H. resigned as the Deputy for the Health Resources Administration in February 2009. Dr. Fukino took over supervision of HRA including FHSD

upon Dr. Barrett's departure. However, due to the increasing workload caused by the budget shortfall and the H1N1 influenza outbreak, FHSD will be under the supervision of Ms. Susan Jackson, the Administrative Deputy, from June 1 2009. //2010//.
An attachment is included in this section.

D. Other MCH Capacity

There are approximately 418 full-time equivalent employees in FHSD. This includes temporary and permanent positions. Of the total, roughly 45 FTEs are funded using federal Title V monies (7 at Division level, 18.5 at CSHN Branch and 19.5 at MCH Branch). Most of the Title V funded positions have been created to build the Division/Branch level infrastructure capacity.

/2008/ There are now roughly 40 FTEs funded using Title V monies (5.5 at Division level, 13 at CSHN Branch and 16.5 at MCH Branch). //2008//

Approximately 105 FTEs of the Division employees are based in the three district health offices on the neighbor islands: 67 FTE on Hawaii island, 12 on Kauai and 26 on Maui.

/2008/ Approximately 88 FTEs of the Division employees based on the three district health offices on the neighbor islands: 53 FTE on Hawaii island, 13 on Kauai and 22 on Maui. //2008//

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 planners at Division and MCHB; and 11 data processing staff at Division and at WIC and CSHNB.

/2008/ The Division now has 13 data processing staff. //2008//

/2007/ The Title V Program lost its full-time CDC-assigned epidemiologist in September 2005, who will not be replaced by CDC. Recruitment of qualified epidemiologists is difficult in Hawai‘i without a School of Public Health. Presently, a small public health program exists within the University of Hawai‘i School of Medicine. Furthermore, the state personnel system does not have a permanent epidemiology job classification which complicates recruitment and hiring. The FHSD Division Chief is currently spearheading efforts on behalf of the Department of Health to create an epidemiologist job series.

To address the need for an MCH epidemiologist, federal State System Development Initiative (SSDI) funds are being requested to establish an epidemiologist position that will be covered at 75% time. Initially, the balance of position funding will likely be provided by the Title V MCH Block Grant. //2007//

/2008/ Efforts to create a permanent epidemiologist job series in the state civil service system is in process and for FHSD, tied to approval of the Division reorganization concept, the first step in the process of developing a final reorganization plan.

Fortunately, the Title V program was able to negotiate with the Centers for Disease Control (CDC) to have an epidemiologist assigned to Hawai‘i. Funded by Title V, Don Hayes, M.D., M.PH. will be joining the Family Health Services Division as the CDC-assigned epidemiologist on July 9, 2007. //2008//

/2009/ Dr. Hayes has joined the staff. The DOH effort to create an epidemiologist job series has been abandoned. Instead, legislation was introduced to allow DOH to establish up to 10 epidemiologist positions, although the positions do not come with state funding. The Lt. Governor signed the bill in May 2008. FHSD is expecting to receive one of the positions. //2009//

/2010/ The Director of Health has assigned one of the epidemiologist positions to FHSD, when finalized FHSD expects to use to the slot for the PRAMS Coordinator position which is currently listed as a program specialist.//2010//

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.

/2007/ The Governor continues to scrutinize the filling of state funded vacancies. This requirement may change as Hawaii is enjoying a period of economic rebound, where unemployment is among the lowest in the country. //2007//

/2008/ With Hawaii experiencing a strong economy, FHSD has benefited from strong administrative and legislative support to sustain and in some areas expand capacity. Additional funding for contractual services, as well as new positions have been granted to the Division to better meet the needs of community health services, early intervention services, family planning services, child health and children with special health needs services. //2008//

/2009/ Based on a reduced revenue forecast for the state, Governor Lingle announced in June 2008 a 4% general-fund spending restriction for next fiscal year for all state departments. This is in addition to a 4% restriction imposed by the State Legislature. //2009//

/2010/ Because of the worsening budget situation, FHSD experienced a 10% reduction in its general fund appropriation. This results in the elimination of 9 positions (2 MCH Branch, 7 CSHN Branch); the initial abolishment of Healthy Start home visitation program, later reinstated with a substantially reduced budget or $4.5M with Tobacco Settlement and TANF funds; a 4% reduction to subsidies for safety net care; the funding for Community Health Centers must also rely upon cigarette tax revenues. Three day a month furloughs have been order by the Governor for the next two years and a hiring freeze for state funded positions has been instituted. The Department has been asked to reduce the budget by another 10%. At the time of this report, the full impact of this has not been determined. //2010//

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 four years. Her area of expertise for twenty-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 the Good Beginning Alliance. She is the current President of the Hawaii Public Health Association, immediate Past President of the Association of State and Territorial Public Health Social Workers, and is a member of AMCP's Work Force Development committee.

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 for eight years. She graduated from the University of Hawaii (UH) with a degree in Biology and received her M.D. from the University of California San Francisco, in 1976.

She pursued pediatric residency with the University of Hawaii/School of Medicine/Department of Pediatrics at Kapiolani Medical Center for Women and Children and later received her Masters in Public Health from UH specializing in Maternal and Child Health. Her prior experience includes Medical Consultant to the MCH and School Health Services Branches, and clinic pediatrician and Clinical Director for the Waimanalo Children and Youth Project (serving a rural Hawaiian community on the island of Oahu). She serves on numerous advisory bodies and committees concerning CSHCN. She provides medical consultation for CSHNB programs, as needed.

ALTHEA MOMI KAMAU, Maternal and Child Health Branch Chief
Althea Momi Kamau, RN, BSN, MPH, has 38 years of experience in maternal and child health and public health nursing. She has served as Maternal and Child Health Branch Chief since 2000 after serving as MCHB Supervisor for Children Health Services for 4 years. Her experience in the Department of Health includes Public Health Nursing Assistant Branch Chief, Support Services Supervisor in the School Health Branch, EPSDT Program Head in MCHB, and 16 years as a public health nurse. She also worked for 7 years in the rural Hawaiian community of Waianae, Oahu overseeing school based health and employment services to adolescents.

/2009/ Momi Kamau retired in August 2007. Her position is currently filled with interim Chief, Dr. Lori Kamemoto who is an Ob/Gyn. The search for a permanent replacement is currently underway.//2009//

/2010/ In February 2009 Terri Byers was hired as new MCH Branch Chief.

TERRI BYERS, Maternal and Child Health Branch Chief
Terri Byers has over 15 years of dedicated experience in public health and public/private sector legislative experience at the federal and state levels. She served as the acting chief of the DOH Office of Health Care Assurance (a regulatory arm of the Department), long term care project manager/special projects manager, and special assistant to the Director of Health. Prior to joining the DOH, she was vice president of the Healthcare Association of Hawaii, the non-profit organization representing Hawaii's healthcare providers including all of the acute care hospitals, home care agencies and hospices, as well as community based providers and supporting organizations. She also worked for twelve years on Capitol Hill working for two members of the Hawaii Congressional delegation. //2010//

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. Her 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.

CHARLENE GASPAR, Nurse Consultant
Ms Gaspar, RN, MPH has over 35 years of experience in maternal and child health and public health. Her field experience in community based public health nursing took place in rural areas of the state and most of her career has been in administering public health programs and grants. She has been the director of the Rural O‘ahu Family Planning Project and the Hilo Maternity and Infant Care Project on the island of Hawaii. As nurse consultant for the Title V agency in Hawaii for over 15 years, her role has evolved from primarily providing nursing consultation to planning and administration. She currently coordinates the federal Primary Care Office and State Systems Development Initiative grants, and the development of the Title V Annual Report and Application. /2007/ Charlene Gaspar retired at the end of 2005. Her position will not be replaced. She is presently on contact to assist with transition of her duties.//2007//

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 oversees two training grants, the Hawaii MCH LEND program(interdisciplinary training) and the Hawaii Dyson Initiative(community pediatrics). 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 immediate past president of the American Academy of Pediatrics-Hawaii Chapter where she advocated for child health issues related to Title V and AAP initiatives (e.g. Family Voices Early Intervention and Transition projects, the Medical Home primary care provider, Early Periodic Screening Diagnosis and Treatment (EPSDT) services, Medicaid child health financing, primary prevention community coalitions).

PARENT INVOLVEMENT IN CHILDREN WITH SPECIAL NEEDS PROGRAMS
The Children with Special Needs programs involve families in various ways, including councils, task forces, and advisory committees; development and review of client education 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 stipend or payment on an hourly basis as appropriate; airline coupons and ground transportation for Neighbor Island families; and child care during activities. Family participants are of diverse ethnic and cultural backgrounds. For more information on family participation initiatives see the narrative on National Performance Measure 02.

E. State Agency Coordination

DEPARTMENT OF HEALTH
Within the Department of Health, Title V works with the District Health Offices and various Divisions/programs including Community Health, Developmental Disabilities, Dental Health, Child and Adolescent Mental Health, Alcohol and Drug Abuse, Communicable Disease, Emergency Medical Services, Office of Health Status Monitoring, the State Health Planning Agency as well as the Environmental Health Administration.

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.

The Title V program participates in the DOE-DOH Comprehensive School Health Program (CSHP) infrastructure development collaborative funded by the Centers of Disease Control and Prevention to establish interagency leadership to support the implementation and sustainability of the CSHP.
/2010/ CSHP is no longer funded by CDC. 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.//2010//

Title V also provides assistance to the DOE Peer Education Program located in 26 high and middle schools to help students develop healthy lifestyles addressing risk behavior including sex assault, violence, teen pregnancy, teen suicide, substance abuse, and STD/AIDS. Title V also organized and participates in an interagency committee to administer the major school health surveys.

/2008/ DOE Peer Education program is now in 19 high and middle schools.//2008//
/2009/ DOE Peer Education programs are now in 22 high and middle schools.//2009//

/2010/ The PEP Coordinator position has been eliminated due to budget restrictions. Oversight for PEP will be transferred to the Educational Specialist for Health and Physical Education.//2010//

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

a) The State Improvement Grant is a collaborative effort of the DOE, University of Hawaii (UH) Center on Disability Studies, DOH/EIS, and DOE/Parent Training Information Center to improve systems providing early identification, educational, early intervention, and transitional services to children with disabilities. Through a Memorandum of Agreement (MOA) with DOE, EIS is funded to identify and address barriers to early identification of infants/toddlers with disabilities, improve the process of transitioning eligible children and their families from the Early Intervention Program to DOE preschool special programs or other options, and assist in the process and outcome evaluation plan.

b) EIS and DOE developed transition materials and regularly provide joint training to early interventionists, DOE staff, families, and other community members.

c) To support the transition of young children with autism, the DOE is utilizing space at an early intervention program for a DOE classroom and regularly includes children under age 3 with autism in classroom activities.

d) EIS and DOE are continuing a pilot project to support the continuation of early intervention services as an Extended Year Services option for eligible children who turn age 3 during the summer months and are eligible for DOE preschool special education services.
/2008/ The project has evolved to an EIS Summer Transition Project to support the continuation of early intervention services for DOE-eligible children who turn 3 during the summer months until their DOE school year starts. EIS identifies appropriate children and DOE supports the funding of the project. //2008//

e) EIS collaborates with the DOE and DOH/Child and Adolescent Mental Health Division (CAMHD) by implementing internal reviews for children from birth to age 3. EIS also participates in an Interagency Quality Assurance Taskforce that includes DOE, CAMHD, DHS, and Hawaii Families as Allies.
/2008/ Internal reviews are now conducted for children in the transition process from EIS to DOE. //2008//

WIC serves with various representatives from the DOE on a variety of committees. In certain cases, WIC works closely with the DOE nutritionists 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, Temporary Assistance to Needy Families (TANF), Food Stamps, Child Welfare Services, Disability Determination, Vocational Rehabilitation, Child Care Services, and Youth Services Programs.

DHS provides funding to FHSD for early intervention services provided by the EIS, Healthy Start, and Public Health Nursing Branch, through a carved-out, non-risk, capitated plan offered by DOH for QUEST-eligible infants and toddlers who are developmentally delayed or biologically/environmentally at risk.

DHS provides funding support for EIS, for the following:
a) Inclusion Project provides tuition support for infants/toddlers with developmental delays to participate in child care or community-based program.
b) Keiki Care Project provides technical assistance and training to community preschool staff

serving children ages 3-5 with behavioral challenges and their families.

Healthy Child Care Hawaii (HCCH) receives funding from DHS for recruiting, training, and linking health consultants to child care programs; training pediatric residents in early childhood/child care, and promoting the Caring for Our Children national health and safety performance standards, medical home, and health insurance.
/2010/ DHS now provides funding to the University of Hawaii for this project. CSHNB continues to be a part of the HCCH team. //2010//

MCH Branch is a member of the DHS EPSDT Advisory committee and partners with DHS to conduct assessment and planning to assure prevention services that focus on family strengthening are available to those in need. A recent agreement between the DHS Medicaid Agency and DOH resulted in a coordinated statewide response to children with elevated lead levels.
/2008/The agreement between the DHS and DOH no longer exists. Effective July 2007, a new standardized EPSDT Examination Form will be implemented by providers resulting in improved data for Title V. //2008//
/2010/ DHS has no plans to reconvene the EPSDT Advisory committee and is using other methods to assure diverse community participation and expert advising including topical meetings and focus groups.//2010//

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.

DHS agreed to use surplus TANF funding for teen pregnancy prevention efforts. Title V helped facilitate discussions among key stakeholders to identify effective strategies to utilize the funding.

DHS has supported the implementation of teen pregnancy prevention training programs with TANF funds including an administrator position in MCHB. Title V partners with DHS and the DOE to oversee training projects with the University of Hawaii; Kapiolani Medical Center for Women and Children Teen Intervention Program; and the John A. Burns School of Medicine, Department of Public Health Sciences and Epidemiology for evaluation of these programs.
/2007/ The TANF funded position in the MCHB is a program specialist (not administrator). Title V staff also provide coordination and technical assistance to integrate a positive youth development approach in other TANF funded programs. //2007//
/2008/ Title V partners with DHS to oversee teacher training projects with the DOE and the University of Hawaii. The program with Kapiolani Medical Center for Women and Children and the program evaluation with John A. Burns School of Medicine was discontinued December 2006. In 2007 TANF funding will be used for family planning community health educator positions to increase family planning information and outreach for populations in need.//2008//

Families that qualify for DHS services (Food Stamps, TANF and Medicaid) are automatically income eligible for WIC. Thus, 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.

DHS Disability Determination Branch 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. These are "rehabilitation" services required by Title V for individuals under age 16 years receiving benefits under Title XVI of the Social Security Act.

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, but not limited to, 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.

EXAMPLES OF PUBLIC AND PRIVATE COLLABORATION

The 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, legislators, pediatrician, and representatives from the DOH, DOE, DHS, University of Hawaii (UH), and health insurance. Membership of the HEICC will be expanded to meet the new requirements in IDEA 2004.
/2008/ HEICC membership expanded in 2006. Additional members include parents of children under age 12 years, and state agency representatives specific for provision/payment of early intervention services, special education preschool services, Medicaid program, foster care, child care, education of homeless children, and children's mental health. //2008//

The Creating Opportunities for All Children (COACH) Project is an EIS project funded by the DOH/Child and Adolescent Mental Health Division through a MOA. This project provides technical assistance and consultation to community preschool staff serving children ages 3-5 who were in early intervention services, are not DOE eligible, but continue to have social/emotional/behavioral challenges.
/2008/ Project ended in 2006.//2008//

Tracking, Integration and Research for Early Screening, Assessment, and Intervention (EASI) project is a collaborative effort of CSHNB with the UH Center for Disabilities for data integration and research studies related to early hearing detection and intervention. EIS provides space and use of equipment to UH Center for Disabilities Studies staff.
/2008/ Project ended in 2006.//2008//

The Special Education Advisory Council (SEAC) is an advisory committee to the Superintendent of Education for policies on any issues in the education of students with disabilities. Appointed membership, as specified in the Individuals with Disabilities Education Act, includes representative of consumer advocate groups, parents, individuals with disabilities, regular and special education personnel, DOH, DHS, and UH. The Council has been actively working with the DOE to enhance the work environment and improve the recruitment and retention of qualified special education teachers and other support staff. The Council is working with the DOE to implement a Comprehensive Student Support System (CSSS) and school-based mental health services, training initiatives, and addressing the educational needs of special education students within the Justice System. EIS is represented on SEAC.

The Newborn Metabolic Screening Advisory Committee consists of consumers and professionals (physicians, laboratory personnel, nurses from various birthing facilities, medical insurance plan representatives, parents, and other DOH representatives) from the private and public sectors. The committee's purposes are 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.

The Hawaii Birth Defects Program (HBDP) Advisory Committee is composed of representatives from the community, medical, university, and public and private sectors. Members offer scientific guidance and input into the program and have expertise in the areas of children with special health needs, service delivery, epidemiology, research, family health, fetal diagnosis, genetics,

health information management, maternal and child health, neonatology, nursing, pediatrics, perinatology, public health, and fetal/pediatric ultrasonography.

The 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.

The Healthy Child Care Hawaii Advisory Team includes the American Academy of Pediatrics (AAP)-Hawaii Chapter, UH/Department of Pediatrics-Dyson Initiative, DOH, DHS, DOE, parents of young children, pediatrician health consultants, early childhood centers, Head Start, Hawaii Association for the Education of Young Children, Hawaii Medical Home Implementation Project, Dyson Initiative, Hawaii Covering Kids, Good Beginnings Alliance, and People Attentive to Children.

The Early Hearing Detection and Intervention Advisory Committee advises the Newborn Hearing Screening Program, the Baby Hearing Evaluation and Access to Resources and Services (HEARS) Project, and the Tracking, Integration and Research for Early Screening, Assessment, and Intervention (EASI) Project. The committee includes: parents, AAP-Hawaii Chapter, Center for Disabilities Studies, early intervention programs, Hawaii Academy of Audiology, Hawaii Speech Language and Hearing Association, Hawaii Center for the Deaf and Blind, UH/Department of Pediatrics, hospital newborn hearing screening program, Gallaudet University regional center, Hawaii Kids Count, and pediatric audiologists.

Hawaii Community Genetics (HCG) is a partnership of DOH/CSHNB Genetics Program, Kapiolani Medical Center for Women and Children, Queen's Medical Center, and University of Hawai`i John A. Burns School of Medicine to develop clinical genetics and metabolic services in Hawaii. HCG has successfully recruited a full-time geneticist for clinical services. Clinical genetics services are expanding with the addition of a hemoglobinopathy clinic, neighbor island clinics, and telemedicine visits.
/2008/ HCG has recruited an additional 0.5 FTE geneticist.//2008//
/2010/ 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. The demand for genetic services is increasing in Hawaii, so HCG is recruiting for one and possibly, two additional full-time M.D. geneticists. //2010//

The core team of CSHNB, Family Voices, UH/School of Medicine/Department of Pediatrics, and American Academy of Pediatrics-Hawaii Chapter, with other key state/community partners, continues to work closely together in various projects toward achieving the six core outcomes for CSHCN. Current collaborative projects are Medical Home Implementation Project, Hilopa`a Project--Integrated Services for Children & Youth with Special Health Care Needs, and a transition & family leadership project funded by the Champions for Progress Center (MCHB cooperative agreement with Utah State University that provides leadership support for state Title V/CSHCN programs in systems building).
/2008/ The current collaborative project is the Hilopa‘a Project. Other projects have ended. //2008//
/2010/ The Hilopa‘a Project ended in April 2009. Project components, such as Rainbow Book training, are continuing where possible. //2010//

CSHNB is a member of the State Council on Developmental Disabilities. Act 175 of the 2001 Legislature required that the Council's membership include a representative of Title V of the Social Security Act. The Council's responsibilities include: development of the state plan which guides the development and delivery of all services for individuals with developmental disabilities, coordination of departments and private agencies, evaluation, and advocacy.
/2010/ The FHSD Medical Director is now the Title V representative on the State Council on Developmental Disabilities. //2010//

The Early Childhood Comprehensive System (ECCS) Strategic Management Team 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 Departments of Education, Health, and Human Services, Good Beginnings Alliance, Hawaii Association for the Education of Young Children, Hawaii Medical Home Initiative, Hawaiian family service organizations, Housing and Urban Development, Kamehameha Schools, AAP, and parents.
/2007/ The ECCS plan is being implemented. A grant to support work for an additional 2 years has been submitted.//2007//
/2008/ The ECCS grant was awarded September 2006. //2008//
/2009/ For the 2008 national ECCS Partnership Conference, the Hawaii's ECCS project supported attendance by a team of early childhood partners including the ECCS Coordinator and Principal Investigator, ECC Strategic Management Team Parent Co-Chair, Child Care Administrator's representative, Head Start State Collaboration Office Director, and the Community-Based Child Abuse Prevention Coordinator's representative. In June 2008 Hawaii submitted a Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) proposal to SAMHSA. The proposal was based on the next steps of the ECCS grant and used existing evidence-based programs.//2009//
/2010/Hawaii did not receive a LAUNCH grant award.//2010//

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.

/2009/ The 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.//2009//

The 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.

/2007/ The 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.
The 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 is working towards creating a child safety system that is coordinated, effective, and well-funded. 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.//2007//

/2009/ The CSC serves as a voice to speak for the safety of children/youth and their families through public awareness, education, advocacy, and action. //2009//

/2010/ The 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.//2010//

/2010/ The Maternal Child Health (MCH)/Injury and Violence Prevention Integration Project is a joint effort between Hawaii DOH 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 staffing support, technical assistance, and training for the project.//2010//

/2010/ The 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. //2010//

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 Task Force on Pediatric Obesity at Kapiolani Medical Center for Women and Children is an organization initiated by pediatricians to address the increase rate of childhood obesity in Hawaii. The membership has expanded to include representatives from public and private agencies who are partnering to identify data, strategies and resources in the community to prevent and treat childhood obesity.
/2007/ The Task Force operates as a coalition and was instrumental in securing passage of a state legislative resolution calling for the development of a State Nutrition and Physical Activity plan.//2007//
/2008/ The Task Force has been discontinued.//2008//

The 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.

/2010/The Consortia assisted with the planning of The Hawaii Perinatal Health Summit held in Hawaii County in 2008.//2010//

Healthy Mothers, Healthy Babies (HMHB) Coalition of Hawaii 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.
/2010/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. //2010//

The Hawaii Teen Pregnancy, Prevention and Parenting Council (HTPPC) is a network of public and private agencies and individuals (collaborators) dedicated to improving public information and interagency communication around issues of teen pregnancy prevention and parenting. The HTPPC activities include statewide and community based educational outreach.
/2009/The HTPPC has become Healthy Youth Hawaii a state-wide coalition of leaders sharing a concern about teen pregnancy and a passion for addressing the issue throughout the islands. The Healthy Youth Hawaii 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. //2009//

The Substance Abuse Free Environment (S.A.F.E.) Council is a statewide organization of community and agency representatives who meet to address issues concerning substance using pregnant women. The Council provides leadership and direction for the service delivery needs of the substance using pregnant women. The Council has testified at the legislature, co-sponsored training sessions for professionals, and worked closely with the DOH Alcohol and Drug Abuse Division and the DHS Child Welfare Division to coordinate advocacy efforts and program planning.

The Fetal Alcohol Spectrum Disorders (FASD) Task Force was established in March 2005 to prevent the adverse outcomes from prenatal exposure to alcohol and develop comprehensive systems of care for those affected by FASD. Members include representatives from state agencies, UH School of Medicine, state chapters of ACOG and AAP, Center for Disabilities Studies, the primary health care centers, private providers, and families.

The USDA-FNS Hawaii Council is comprised of the U.S. Department of Agriculture (USDA) and USDA-funded Nutrition and Nutrition Assistance State agencies of the DOH Executive Office on Aging, Department of Labor & Industrial Relations, DHS Food Stamp Program, University of Hawaii's Cooperative Extension Service, DOE, and WIC Program. 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.

/2010/ 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.//2010//

The University of Hawaii Maternal Child Health Program, Department of Public Health, in the School of Medicine was awarded a federal grant to develop the MCH Certificate Program to provide training in data analysis and data-based program management. The program has attracted many Title V and community agency staff and plays a vital role in building public health capacity in the state. MCH faculty provide important technical and research assistance to the MCH community.
/2010/ The MCH certificate program did not receive funding from MCHB-HRSA to continue. This will unfortunately result in closure of the only MCH public health training program in Hawaii and the Pacific, after 9 years of operation and over 30 years as an MCH-specialization MPH program. The program will continue to train existing students in Fall 2009, and potentially the Spring of 2010 under a no-cost extension. //2010//

F. Health Systems Capacity Indicators

Introduction

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 the health 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 (SCHIP is a medicaid expansion) and Medicaid linkage data.

Resident data is used for reporting and planning purposes for Title V infant measures unless noted and is determined by mother's resident area. Those reporting out-of-state addresses (e.g. foreign visitors or some military) are excluded from data reporting and generally amount to fewer than 0.5% of births.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	32.5	27.0	24.4	20.5	18.6
Numerator	284	209	207	177	162
Denominator	87433	77324	84879	86239	87207
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

Notes - 2007

Asthma defined by primary ICD9 codes 493.xx. Hawai‘i residents only. 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, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

Notes - 2006

Asthma defined by primary ICD9 codes 493.xx. Hawai‘i residents only. Population data based on U.S. Census Bureau, Population Estimates Program, SC-EST2006-AGESEX_RES: Annual

Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2006. Release Date: May 17, 2007.

Narrative:
Data for this measure comes from the Hawaii Health Information Corporation (HHIC) a non-profit corporation established to collect inpatient discharge records from Hawaii's 22 acute care hospitals. The rate excludes newborns, pregnancy-related admissions and patients admitted through a transfer from another facility. The denominators are from the U.S. Census.

The rate of pediatric hospitalizations for asthma per 10,000 children continues to decline, although the difference from 2005 is not significant. The Hawaii rate for children under 5 years of age is lower than the Healthy People 2010 Objective of 25 hospitalizations visits per 10,000 children.

The Hawaii State Asthma Control Program (HSACP) is the lead for asthma issues in the Department of Health (DOH). The HSACP designed a Comprehensive State Asthma Surveillance System (CSASS) to measure and track the asthma burden through 4 key indicators: asthma prevalence, asthma severity, asthma management, and asthma cost. The HSACP has published and disseminated two comprehensive reports: State of Asthma-Hawaii 2004 Burden Report, and State of Asthma-Hawaii 2006 Supplement documenting current and lifetime prevalence of asthma, emergency department visits, hospitalizations, health status, health/lifestyle behavior, and mortality.

Roughly, 12.2% or 37,000 children age 0-17 years currently have asthma according to the 2006 Hawaii Behavioral Risk Factor Surveillance System (BRFSS). The survey estimates that 19.4 % or 58,900 children reported having asthma in their lifetime. While children in Hawaii County have a higher current asthma prevalence (16.0 %) than other counties, the finding is not statistically significant.

The Hawaii State Asthma Control Program (HSACP) was established in September 2002, through a cooperative agreement with the Centers for Disease Control and Prevention to develop a comprehensive strategic plan for Hawaii. This plan includes disease tracking, science-based interventions, state-wide collaboration and partnerships to reduce the burden of asthma in the home, school, and workplace.

The HSACP's role is to sustain its efforts by convening of stakeholders and partners, providing an understanding of the burden of asthma, offering technical assistance (guide planning, evidence-based interventions, evaluation, etc.) and appropriate training to assure a coordinated effort across the state.

The HSACP has mobilized community support and a dedicated group of enthusiastic partners that are willing to commit their professional expertise and resources towards the implementation of activities in the Hawaii Asthma Plan 2006-2010 (HAP).

The HSACP will continue to broaden the circle of partners by continually seeking involvement of organizations that serve high-risk groups as well as health agencies serving rural communities.

/2009/ In 2008, a new volcanic vent opened on Hawaii island's Kilauea volcano which has been quietly erupting since 1983, resulting in drastically higher levels of volcanic smog (referred to as "vog"). Before the new vent opened, 200 tons of sulfur dioxide was emitted per day; now the crater releases about 2,000 tons per day. While most of the vog is blown out to sea with regular winds, seasonal weather conditions may keep the vog lingering over Hawaii island, creating conditions serious enough to close the Volcanoes National Park and the issuing of vog alerts that recommend residents to stay indoors. The vog has also been blown over the entire island chain by the seasonal winds. While the short-term exposure to vog can trigger symptoms for those with

asthma, several research studies have shown exposure to vog is not responsible for higher rates of asthma among children on Hawaii Island. While the long term effects of vog are largely unknown state health officials continue to monitor the situation.//2009//

/2010/Asthma rates continue to improve. The Kilauea volcano continues to be active resulting in vog that blows over the islands. The DOH has a sulfur dioxide monitoring station and there is a daily action plan to protect children from the vog on Hawaii island. Children with respiratory problems are advised to stay indoors or in a safe air conditioned room when the level of sulfur dioxide is unhealthy.

DOH established the Volcano Helpline in August 2008 for the public to obtain information on volcanic emissions by trained professionals who will answer questions and via recorded messages. The HSACP provided supplemental funding to keep the hotline in operation to Dec 2009 due to the increase in callers over the last few months.

The Asthma-Friendly Schools Project is designed to improve asthma care in the State's public schools and is set to start in September 2009. The goals are to promote asthma-friendly school policies, such as tobacco-free campuses, protocols for self-administration of asthma inhalers and on-campus medication storage, and to use less-toxic cleaning methods to maintain healthy indoor air quality. The HSACP will work with schools to adopt asthma-friendly policies.

The HSACP is currently partnering with the Primary Care Association and an Oahu community health center on a Childhood Rural Asthma Project. The project will improve indoor air quality for children with asthma by reducing exposure to known allergens and irritants. The health center staff will identify children with current physician-diagnosed asthma and train outreach workers to implement a comprehensive home-based intervention. //2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	85.2	87.1	87.4	85.3	89.7
Numerator	6925	7141	6960	7292	7779
Denominator	8131	8201	7961	8552	8674
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

Notes - 2007
Data for this measure is from the Centers for Medicare and Medicaid Services (CMS) report form HCFA-416, Annual EPSDT Participation Report. Data for FY 2007 was not available for this report, but will be updated when it becomes available.

Notes - 2006
Data for this measure is from the Centers for Medicare and Medicaid Services (CMS) report form HCFA-416, Annual EPSDT Participation Report. Data for FY 2006 was not available for this report, but will be updated next year.

Narrative:
Data for this measure comes from the Med-QUEST Division (MQD), the Medicaid agency in the State Department of Human Services (DHS), HCFA-416 Annual EPSDT Participation report. The data for 2006 is not available at this time, however provisional data for 2004 and 2005 was updated. Historically, Hawaii has had a high percentage of Medicaid enrollees under the age of one year receiving at least one initial EPSDT periodic screen.

MQD will be requiring all pediatric providers to complete standardized EPSDT reporting forms for all comprehensive screening examinations starting July 1, 2007 for children in all QUEST health plans (managed care) and Medicaid fee-for-service. The data will be used for billing as well as quality assurance purposes. MQD and the Hawaii Chapter of AAP are conducting trainings statewide on the use of the form and its requirements. All completed forms will be submitted to MQD and scanned into a data base system. When available, the information generated will give a clearer picture of EPSDT participation by ages and services.

Title V administers contracts to provide primary care services for the uninsured and perinatal support for women at high-risk for poor birth outcomes. Community health centers statewide that provide services to the uninsured are required to assist families with infants to apply for Med-QUEST insurance. The Perinatal Support Services contract also has a requirement to assist women in applying for insurance. Families are referred to an appropriate program, like Healthy Start Home Visiting Program, after birth.

A grant administered by Title V, Malama A Ho'opili Pono on the Island of Hawaii, a perinatal disparities program designed to decrease infant mortality in the Native Hawaiian and Pacific Islands population, does assure that each newborn has health insurance and well infant check up with a health care provider.

Initially when the infant is deemed eligible for services, the Med-QUEST program sends out information and the schedule of services to the parents. The EPSDT programs within the different health insurance providers have their own provisions to assure initiation of periodic screening. For example, in one program, the infant is scheduled for a two-week EPSDT exam before leaving the hospital (sooner if warranted) and mother is provided with a written schedule of expected well-baby visits. Mother also receives an appointment reminder telephone call the day before the appointment. If she does not bring the infant in for the exam, the clinic tries to contact the family twice by phone and a certified letter. If the child has a medical problem and does not show for a check up, an RN is available for home visits and concerted efforts are made before the Child Protective Service system is activated.

/2009/Statewide WIC services also reinforce the importance of medical periodic screening for infants.//2009//

/2010/Utilization rates continue to improve. As of April 2009, 8,093 children below 1 year of age were enrolled in Med QUEST and 188 in SCHIP. With the passage of the federal Children's Health Insurance Program Reauthorization Act of 2009 infants whose mothers are enrolled in Medicaid will now be automatically enrolled into Medicaid coverage, bypassing cumbersome documentation requirements. This policy change should help to expand coverage to infants and hopefully increase utilization of services.//2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	87.8	87.8	87.8	87.8	87.8
Numerator	403	403	403	403	403
Denominator	459	459	459	459	459
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

Notes - 2008
SCHIP is a Medicaid expansion program in Hawai'i, separate service utilization data is not available for SCHIP enrollees at this time. Thus data for this indicator are estimates. It is questionable whether the Medicaid agency will be able to provide this information in the future. Title V will continue to request this information.

Notes - 2007
Since SCHIP is a Mediciad expansion program in Hawaii, separate service utilization data is not available for SCHIP enrollees at this time. Thus data for this indicator are estimates. It is unclear whether the Mediciad agancy will be able to provide this information in the future. Title V will continue to request this information.

Notes - 2006
Since SCHIP is a Mediciad expansion program in Hawaii, separate service utilization data is not available for SCHIP enrollees at this time. Thus data for this indicator are estimates. It is unclear whether the Mediciad agancy will be able to provide this information in the future. Title V will continue to request this information.

Narrative:
Since SCHIP is a Medicaid expansion program in Hawaii, separate service utilization data is not available for SCHIP enrollees at this time. It is unclear whether the Medicaid agency will be able to provide this information in the future. Title V will continue to request this information.

As of January 2007, 16,885 children were enrolled in the State Children's Health Insurance Program (SCHIP) program. Enacted by the Federal government in August 1997, SCHIP provides incentives for states to extend public health insurance coverage to greater numbers of children from low-income families.

These incentives include a higher Federal funding match and greater flexibility to design SCHIP programs. Hawaii uses Tobacco Settlement revenues to fund the State match for SCHIP, and there is no assets test.

DHS implemented Hawaii's SCHIP program on July 1, 2000, by offering health insurance coverage to all children under 19 years of age with family incomes up to 200 percent of the FPL. Under the new 1115 waiver, the income eligibility level was raised to 300 percent of the FPL in 2006. There is no waiting period for SCHIP eligibility.

Refer to HSCI #02 for narrative on programmatic efforts to improve this indicator.

/2009/ As of February 2008, 18,675 children were enrolled in the SCHIP program.//2009//

/2010/ Although separate SCHIP utilization rates are not available, EPSDT rates show

continued improvement of service utilization rates for infants. As of April 2009, 20,720 children were enrolled in the SCHIP program. More than 5,500 additional children enrolled in Hawaii's Medicaid programs during the past two years. This is likely due to SCHIP eligibility expansion, greater outreach by Hawaii Covering Kids, and Medicaid application and processing simplification. Over the past year the economic downturn and continued layoffs may also account for expanded SCHIP enrollments. //2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	67.3	66.7	65.9	67.7	67.7
Numerator	12244	11897	12436	12878	13105
Denominator	18186	17829	18873	19020	19348
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

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated birth data file. Data for the year 2007 is based on a provisional birth data file.

Notes - 2006
Data is for resident population and is by calendar year. Data for the year 2005 was revised with an updated birth data file. Data for the year 2006 is based on a provisional birth data file.

Narrative:
FY 2006 data is provisional as the final birth record file is not complete. The data indicates the adequacy of prenatal care visits appear to be declining slightly over the past 5 years. Reasons for decline can be attributed to the lack of Obstetricians on the neighbor islands. Conducting a medical practice on the outlying islands from Oahu is not feasible for most providers. The few medical providers whether Obstetrician or General Practice have appointment dates with 2-3 weeks wait periods. The island of Lanai has no Obstetrical (OB) services and pregnant women must catch an airplane or ferry to receive OB or specialty care. The Community Clinic on Maui is overburdened in providing services to most uninsured or Medicaid insured pregnant women. There are five OB providers on Kauai for approximately 800 births a year.

Title V funds statewide Perinatal Support Services (PSS) contracts to promote early and continuous prenatal care. PSS provide enabling services such as transportation services and care coordination to ensure regular and adequate prenatal visits. The Baby S.A.F.E. (Substance Abuse Free Environment) Program, another Title V funded contract, provides outreach, screening/assessment for early identification of substance using pregnant women needing OB and pretreatment services. Baby S.A.F.E. Programs are located on Oahu, Maui Island, and Hawaii Island.

The Malama A Ho'opili Pono federal Healthy Start Perinatal Disparities Grant for Hawaii County targets perinatal support services for high risk pregnant women who are Hawaiian, Pacific

Islander, and Filipino. This disparities grant employs neighborhood women to conduct community-based outreach, and assistance with language, cultural barriers and perinatal health education to promote engagement in early and ongoing prenatal care.

Entry into early prenatal care is a performance measure for the PSS, Baby S.A.F.E. and Malama Program contracts.

Immigrants from the Republic of Marshall Islands (RMI) and the Federated States of Micronesia (FSM) are a growing immigrant population in Hawaii and many pregnant women from these groups arrive in Hawaii late in their pregnancy and therefore access prenatal care after the first trimester. Several Federally Qualified Health Centers provide PSS services to immigrant groups and employ bilingual outreach workers to assist immigrant women in receiving regular and adequate prenatal care. Women from these population groups were more likely to seek early prenatal care for subsequent pregnancies once they adapt to the local environment and culture.

In 2004, the Department of Health and Human Services Office of Minority Health awarded a three-year grant to the Kokua Kalihi Valley Clinic to spearhead a Bilingual/Bicultural Demonstration Project. The Kokua Kalihi Valley Comprehensive Family Services established a Cross Cultural Bridges Program which focuses on bridging the gap between healthcare providers and the growing numbers of Limited English Proficient immigrant and migrant populations in Hawaii. Additional funding from a March of Dimes Hawaii Chapter 2006 Community Grant was used to improve the effective use of maternal and child care services for pregnant women with Limited English Proficiency living in Kalihi Valley and throughout the State of Hawaii. Program activities include Hawaii's first specialized Medical Interpreter Training for bilingual health paraprofessionals; conducting cultural competency workshops for healthcare providers; and developing and implementing a Cross Cultural Childbirth Education Series targeting pregnant Chuukese, Samoan and Tagalog-speaking women.

A CenteringPregnancy(r) instructional workshop for health care professionals sponsored by the Kalihi-Palama Health Center will be conducted in June 2007. This model provides prenatal care for women in a group setting, incorporating the three elements of prenatal care: assessment, education, and support into an integrated format that takes place within the group. The model encourages women to take responsibility for themselves and to interact positively with the health care system.

The Department of Human Services is authorized to provide state-funded medical assistance for pregnant legal immigrants who entered the United States on or after August 22, 1996, who are age 19 or older, and whose countable family income does not exceed 185% of the federal poverty level for Hawaii. These pregnant legal immigrants would otherwise not quality for Medicaid.

/2009/Average wait periods for a prenatal care visit is up to 5 weeks for the neighbor islands. The Perinatal Advocacy Network hosted a speaker on Micronesian culture, providing insight and useful approaches for encouraging early/continuous prenatal care in June. The 1st Centering Pregnancy group session was held in September 2007. Additional funding from the March of Dimes will continue this model for a 2nd year.//2009//

/2010/ There was little change in FY 2008 indicator. The data is provisional and will be updated next year. For updates on efforts to improve prenatal care see the narrative for NPM 18. //2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	67.3	71.7	72.3	62.9	75.5
Numerator	81758	90273	91323	92301	100014
Denominator	121477	125902	126344	146692	132459
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

Notes - 2007
Data for this measure is from the Centers for Medicare and Medicaid Services (CMS) report form HCFA-416, Annual EPSDT Participation Report. Data for FY 2007 was not available for this report, but will be updated when it becomes available.

Notes - 2006
Data for this measure is from the Centers for Medicare and Medicaid Services (CMS) report form HCFA-416, Annual EPSDT Participation Report. Data for FY 2006 was not available for this report, but will be updated next year

Narrative:
FY 2005 is the latest available data that shows 71.1% of potentially Medicaid-eligible children received a service paid by the Medicaid program an increase over the past 2 years.

The numerator is obtained from service data collected by the Department of Human Services (DHS) Medicaid program. The denominator is the sum of 1) Medicaid enrollment numbers provided by DHS and 2) numbers of uninsured Medicaid eligible children as reported by the annual Hawaii Health Survey (HHS). Data from the 2006 HHS and Medicaid data were not availalble and will be updated in next year's report.

Med-QUEST will be requiring a new EPSDT reporting form for all comprehensive screening examinations starting July 1, 2007 for billing as well as data collection purposes. Med-QUEST and the Hawaii Chapter of AAP are conducting trainings statewide on the use of the form and its requirements. All completed forms will be submitted to Med-QUEST and scanned into a data base system. When available, the information generated will give a clearer picture of EPSDT participation by ages and services.

This indicator builds on National Performance Measure (NPM) #13, which focuses on increasing insurance coverage for children and emphasizes outreach and enrollment of uninsured Medicaid-eligible children. The activities under NPM #13 affect the denominator in HSCI #7A. The major activities under HSCI #7A affect the numerator, the number of Medicaid-eligible children who have received a service paid by the Medicaid program. These activities have focused on improving utilization of services.

The Title V agency's efforts to increase the percent of potentially Medicaid-eligible children receiving a service paid by the Medicaid program are primarily 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 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.

Title V participates on the Med-QUEST EPSDT Advisory Committee that consists of EPSDT care coordinators from each of the participating health insurance plans, the Med-QUEST medical director and the Med-QUEST EPSDT coordinator, agencies involved with children and other programs in the Department of Health. The Committee continues to explore avenues of increasing EPSDT utilization.

Working with Med-QUEST, the Title V agency is attempting to generate an analysis of provider visits by child age to ascertain the ages where there is decreased utilization, especially of EPSDT services.

/2009/ The Med-QUEST Administration is currently restructuring the EPSDT Advisory Committee, including membership and functions, to ensure effective use of future electronic utilization data to ensure improved utilization rates. //2009//

/2010/The FY 2008 EPSDT utilization rates for this measure increased substantially after a sharp decline in 2007. The reason for the variability in rates is unknown at this time.

The Med-QUEST Administration has no plans to reinstitute the previous EPSDT Advisory Committee. Instead the Medicaid Program has decided to work with the health plans to improve the rate of EPSDT screenings through ad hoc committees and focus group meetings. Meetings held over the past year addressed Childhood Obesity, the EPSDT Transformation Grant to improve data collection, Access to Care, and the Hawaii Head Start Dental Home Partnership. Community providers are invited to participate and give input at these meetings. This approach assures EPSDT captures more diverse community/agency participation and expert advice.

Through the Hawaii EPSDT Transformation Grant, DHS is developing an electronic health record (web-based registry) and information exchange to enable the State and providers to monitor and manage the compliance rates, improve care coordination among providers and minimize duplication of services. //2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	43.1	54.0	53.3	47.7	56.4
Numerator	10069	12998	12933	13633	14420
Denominator	23378	24060	24262	28557	25556
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

Notes - 2007

Data for this measure is from the Centers for Medicare and Medicaid Services (CMS) report form HCFA-416, Annual EPSDT Participation Report. Data for FY 2007 was not available for this report, but will be updated when it becomes available.

Notes - 2006
Data for this measure is from the Centers for Medicare and Medicaid Services (CMS) report form HCFA-416, Annual EPSDT Participation Report. Data for FY 2006 was not available for this report, but will be updated next year

Narrative:
Data for this measure comes from the Med-QUEST Division (MQD), the Medicaid agency in the State Department of Human Services (DHS), HCFA-416 Annual EPSDT Participation report. The data for 2006 is not available at this time, however provisional data for 2004 and 2005 was updated. The decline in 2004 are due to a change in the data collection system at DHS Med-QUEST Division.

Statewide, the Med-QUEST program provides dental services through a fee-for-service system that includes a strong case management component for families who have difficulty accessing dental services. The program also collaborated with dentists to increase reimbursement and decrease the paper work involved with provision of care. The Department of Health's Dental Health Division (DHD) chief is also the consultant for the Med-QUEST dental program.

DHD remains the state's lead agency in children's oral health data. They provide statewide oral screenings every other year and on Oahu and Maui only on the alternate years. Also DHD's dental hygienists conduct education in various public elementary schools, administer fluoride rinse programs in participating schools and follow-up in cases where serious oral health problems are identified. Refer to SPM 05 for statewide activities.

/2009/ Refer to narratives for NPM 9 (protective sealants) and SPM 05 (child dental caries) for statewide activities. //2009//

/2010/ The dental utilization rates for FY 2008 increased slightly over 2007. The Department of Health's Dental Health Division (DHD) chief no longer serves as a consultant for the Med-QUEST dental program. EPSDT is a partner in the Hawaii Head Start Dental Home Initiative to link Head Start children to dental care. For updates on statewide efforts to improve oral health services to children refer to narratives for NPM 9 (protective sealants) and SPM 05 (child dental caries). For other efforts to increase EPSDT utilization rates and improve data collection see narrative for HSCI 7A.//2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	30.2	24.6	26.1	34.4	26.4
Numerator	378	324	352	477	350
Denominator	1250	1317	1350	1387	1325
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

Notes - 2007
The numerator is from the Children with Special Health Needs Program. The denominator is from "Table - Number of children under age 16 receiving federally administered SSI payments, by state or other area, December 2007", Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100% data. Table was sent to DOH CSHN Branch by the Healthy and Ready to Work National Center.

Notes - 2006
The numerator is the number of children who are Supplemental Security Income (SSI) beneficiaries less than 16 years who receive services from the Children with Special Health Needs Program. The denominator is from "Table - Number of children under age 16 receiving federally administered SSI payments, by state or other area, December 2006", Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100% data. Table was sent to Hawaii DOH, Children with Special Health Needs Branch by the Healthy and Ready to Work National Center.

Narrative:
The CSHNB/Children with Special Health Needs Program (CSHNP) provides services for children with special health care needs ages 0-21 years, including children under age 16 who are Supplemental Security Income (SSI) beneficiaries. Services include information and referral, outreach, service coordination, social work, medical nutrition therapy, and Neighbor Island clinics. CSHNP social workers provide outreach services to medically eligible SSI applicants referred by Disability Determination Services.

December 2006 data on Hawaii children under age 16 who are SSI beneficiaries were provided by the Social Security Administration (SSA), in a table sent to CSHNB by the Healthy and Ready to Work (HRTW) National Center. HRTW has an informal agreement with SSA to obtain SSI data to provide to states for their MCH Block Grant reports.

/2009/ Data on children under age 16 receiving SSI payments was provided by the CSHNB/Children with Special Health Needs Program, in which social workers and other health professionals provide outreach services to medically eligible SSI applicants referred by Disability Determination Services, and to SSI beneficiaries referred by other community resources. December 2007 data on children under age 16 receiving SSI payments for Hawaii was provided by the Social Security Administration, in a table sent to CSHNB by the Healthy and Ready to Work National Center. //2009//

/2010/ No change for 2008. //2010//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	other	8.1	8	8

Notes - 2010
Data were obtained from hospital discharge records acquired from the Hawai'i Health Information Corporation (HHIC)-a private, non-profit corporation that maintains a database of health care encounters in the State.

Narrative:
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.

The SSDI grant director convened a meeting to discuss the topic with the DOH Office of Health Status Monitoring (OHSM), the vital records office; and a liaison from the Department of Human Services (DHS), the Medicaid agency. The meeting focused on a new collaborative effort between OHSM and DHS to verify citizenship/legal immigrant status for Medicaid enrollees and applicants as required by the federal Deficit Reduction Act of 2005. DHS provides client names and other information to OHSM electronically and the information is matched to birth certificate records to provide proof of citizenship. The verification project began in June 2006 and is continuing on a monthly basis.

While OHSM is supportive of pursuing the actual linkage of birth certificates with Medicaid records, several substantial barriers have developed with the current verification project including payment/funding issues, the execution of a Memorandum of Agreement (MOA), and continued turnover of state Medicaid Directors on a yearly basis. SSDI will be monitoring the progress to remedy these issues.

In the future, SSDI will explore an alternative to generate data for this indicator by linking hospital discharge data for Medicaid deliveries with birth/death certificates. The DOH is in the process of contracting with Hawaii Health Information Corporation (HHIC), the state repository for all hospital data, to allow 25 DOH users access to the HHIC online server with virtually full access to both hospital discharge and emergency room data. FHSD will likely receive one of the user memberships. The contract with HHIC is currently pending review before the Attorney General's office and is expected to be approved within the next state fiscal year.

Once direct access to hospital discharge data is attained, SSDI staff will examine the possibility of linking hospital infant delivery records (which indicate Medicaid insured births) with birth and infant death certificates. The linkage between birth certificates and hospital records has been conducted in the past to assess the quality of hospital records. This linkage may be more feasible than the linkage between birth and Medicaid records.

Please see narrative for HSCI #04 for program activities that influence the indicator. Early and regular prenatal care can help to reduce low birth weight and infant mortality rates.

/2009/ The percentage of infants weighing less than 2,500 grams does not vary by Medicaid status in Hawaii (8% in 2006) and there have been no significant trends since 2002.

The DOH effort to purchase a departmental subscription to use the HHIC hospital and emergency room (ER) dataset was not successful due to payment and procurement issues.

Thus, the Title V agency purchased an extracted dataset of mother/infant 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. Analysis was conducted on data for the years 2002-2006.

To reduce the cost of individual DOH Divisions purchasing HHIC data subscriptions, the DOH

Deputy for the Health Resources Administration (which includes the Title V agency), will begin negotiating with HHIC to purchase a multi-user license which should substantially reduce the cost to access the data.

Title V has met with HHIC to explore the possibility of linking hospital infant delivery records with birth and infant death certificates. HHIC had actually conducted a feasibility study for this linkage in 2005 when the linked dataset was generated for a research project. However, issues regarding HIPPA restrictions, administrative concerns, and cost need to be addressed for sustaining on-going linkage. Discussions will be pursued with DOH OHSM (vital records office) and HHIC once the DOH HRA multi-user agreement is finalized.

Title V will also initiate discussions again with the Medicaid agency since a permanent director for the state agency has been hired. The new director is a Family Practice/Preventive Medicine medical doctor and has experience working with the regional CMS office. The data for HSCI 5 will be shared with the new Director and other perinatal stakeholders to garner support for further research, data linkage and to begin discussions about improving perinatal services.

/2010/ There were no changes in the distribution of low birth weight births. The HRA effort to purchase a multi-user Division subscription to use the HHIC hospital and ER dataset was not successful due to same payment and procurement issues that plagued the department negotiations. However, discussion is ongoing with HHIC and OHSM about linkage of data sets.

The new Medicaid Director is currently undertaking an evaluation of the Agency's data system and the out-of-state contractor who manages the system. Linkage discussions are postponed until this evaluation is completed. //2010//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	other	6.3	5.5	6

Notes - 2010
Data were obtained from hospital discharge records acquired from the Hawai'i Health Information Corporation (HHIC)-a private, non-profit corporation that maintains a database of health care encounters in the State.

Narrative:
See narrative for HSCI 5A

/2009/ The rate of infant death is significantly higher among the Medicaid versus non-Medicaid population in Hawaii (8.0 versus 5.9 per 1,000). Future linkage of hospital discharge data to birth certificate data could help determine causes of excess death for the Medicaid population. Knowledge of the determinants of this disparity will help to direct programs to reduce infant death among the Medicaid-insured.

For plans regarding data linkage see narrative for HSCI 5A. //2009//

/2010/ Rate for 2003-2005 aggregate was updated with minimal changes due to reanalysis with updated data provided by HHIC. Overall rates of infant death have declined somewhat in the 2004-2006 aggregate for insurance status with the most prominent decline among those on Medicaid. Validation of this decline and continued surveillance is needed. For updates regarding data linkage see narrative for HSCI 5A. //2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	other	70.3	86.9	80.9

Notes - 2010
Estimates come from the 2007 Hawai‘i PRAMS survey and reflects those with a live birth in Hawai‘i without regard to residency status. The 2008 data reflects data collected during the 2007 calendar year.

Narrative:
See narrative for HSCI 5A.

/2009/ The percentage of pregnant women entering care in the first trimester is significantly lower among women whose deliveries were paid for by Medicaid versus non-Medicaid in Hawaii (67.9% versus 85.5%). The rate of first trimester prenatal care has slowly decreased from 85.4% in 2000 to 80.1% in 2006. This decline occurred irrespective of insurance type and may be due to increasing physician shortages and other factors. Further investigations into this troubling trend are planned.

For activities addressing prenatal care see National Performance Measure 18.

For plans regarding data linkage see narrative for HSCI 5A. //2009//

/2010/ The rate for 2007 was updated with minimal change due to changes in how Medicaid status was calculated. There has been no change between the two reporting periods for receipt of Prenatal Care in the first trimester based on Hawaii PRAMS data. For updates regarding data linkage see narrative for HSCI 5A.//2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

indicators for Medicaid, non-Medicaid, and all MCH populations in the State					
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	other	68.3	75.4	72.5

Notes - 2010
Estimates come from the 2007 Hawai‘i PRAMS survey and reflects those with a live birth in Hawai‘i without regard to residency status. The 2008 data reflects data collected during the 2007 calendar year.

Narrative:
See narrative for HSCI 5A.

See narrative for HSCI 5A.

/2009/ The percentage of pregnant women entering care with adequate or adequate-plus prenatal care is significantly lower among women whose deliveries were paid for by Medicaid versus non-Medicaid in Hawaii (59.1% versus 69.4%). Similar to the rate of first trimester prenatal care, the percentage of women with adequate or more prenatal care has decreased from 77.3% in 2000 to 65.9% in 2006. Again, this decline occurred irrespective of insurance type and may be due to increasing physician shortages and other factors. Further investigations are planned.

For activities addressing prenatal care see National Performance Measure 18.

For plans regarding data linkage see narrative for HSCI 5A. //2009//

/2010/ The rate for 2007 was updated with minimal change due to changes in how Medicaid status was calculated. There has been an apparent increase in the adequacy of prenatal care received between the two reporting periods based on Hawaii PRAMS data. Those on Medicaid were less likely to receive adequate prenatal care compared to those that were not on Medicaid. The significance and validation of these findings are uncertain and concerning with increasing physician shortages. For updates regarding data linkage see narrative for HSCI 5A. //2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	300

Narrative:
In Hawaii the Department of Human Services (DHS) is the Medicaid agency. Hawaii's SCHIP Program is a Mediciad expansion that expanded coverage for children up to age 19 up to 200% FPL. In 2006 DHS received approval from the federal Centers for Medicare and Medicaid Services (CMS) to expand the SCHIP health insurance to cover children up to 300% FPL. The waiver allows children in families with incomes between 201 and 250% FPL to qualify for Medicaid coverage (both QUEST managed care and Fee-for-Service) at no charge. There is no waiting period or assets test.

In addition the waiver reduced the monthly co-share premiums for children of families whose income falls between 251 and 300% FPL. A family making 251-265% of the poverty level pays $15; for those earning 266-280%, the fee is $30; and for those families whose income is between 281-300%, the premium is $60. In the past, a family making more than 200% of the FPL was required to pay $60 per month.

The Keiki Care bill passed recently by the 2007 Legislature and signed into law by the Governor is a 3-year pilot program established to expand health care coverage for uninsured infants and children living in Hawaii. The State will pay monthly premiums for children enrolled in QUEST-Net (251-300% FPL); and there is household income parity between the state-funded Immigrant Children's Plan and Med-QUEST's State Children's Health Insurance Program.

The bill has an effective data of January 2008, however, DHS will need to secure permission from CMS to amend eligibility requiements for QUEST-Net to open the program to all income eligible children.

/2009/ No change in eligibility. CMS approval was received and the Keiki Care program is now in effect. For updates on programmatic efforts to reduce the rate of uninsured children refer to the narrative for NPM 13 on children without medical insurance. For updates on the Expanded Access program for the Aged, Blind and Disabled (ABD population) see narrative in the Overview section. //2009//

/2010/ There is no change in eligibility. In April 2008, the State's 3-year pilot Keiki Care plan went into effect providing free health insurance for children ineligible for Medicaid. However, the Governor halted funding for the program given a projected $900 million state budget shortfall at the time. The program was ended in December 2008 with 2,040 children enrolled.

The 2009 Legislature restored limited funding to the Keiki Care program, requiring health care services be delivered through federally qualified health centers. The new program will cover approximately 30% of the previous Keiki Care enrollment, however the bill is on the Governor's veto list at the time of this report. //2010//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 14) (Age range 15 to 18)	2008	 133 100 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**

women.		
Medicaid Children (Age range 1 to 5) (Age range 6 to 14) (Age range 15 to 18)	2008	 300 300 300

Narrative:
See narrative for HSCI 6a.

/2009/ No change in eligibility.//2009//

/2010/ No change in eligibility. See HSCI 6a for other insurance coverage updates for children.//2010//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	

Notes - 2010
Hawai'i's SCHIP program is a Medicaid expansion for children up to 18 years of age and does not include pregnant women over that age.

Narrative:
Eligibility requirements for Medicaid and SCHIP remain the same since 2000. Pregnant women must not have family incomes over 185% FPL and the household size includes the unborn child(ren). This compares to a US federal minimum eligibility level of 133% based on the CMS eligibility report 2006.

In Hawaii, pregnant women enrolled in Medicaid whose income exceeds 185 percent of the federal poverty line can purchase alternative coverage by paying a monthly premium. This coverage has an income eligibility guideline of 300 percent of the federal poverty line.

Pregnant women do not have presumptive eligibility for Medicaid in Hawaii.

In the 2007 legislative session, a bill was introduced requesting the Department of Human Services to disregard assets in determining the needs of persons for medical assistance for households with minor dependents. Another bill would require the Department of Human Services to apply a self-sufficiency standard to determine the amount of assistance allowance. In 2003, the Commission on the Status of Women funded a report, "The Self-Sufficiency Report for Hawaii," which provided an in-depth study of the actual cost to live in Hawaii in nine communities throughout the state. The self-sufficiency standards in this study ranged from double to triple the federal poverty guidelines. Both of these bills failed to pass.

/2009/ No change from last year. //2009//

/2010/No change in eligibility. //2010//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	2	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
DATA LINKAGES

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 infant death certificates occurs for infants 1 year old and younger at the DOH Office of Health Status Monitoring (OHSM), the vital statistics office. The Title V program has had access to the linked database for a number of years and has done analysis of the data.

In order to facilitate annual linkage of birth certificate files with other datasets, a State Attorney General's (AG) opinion was requested on linking birth certificate files with newborn screening records. In 2003, the AG's opinion established the legality of linking these datasets and indicated

the linkage could occur.

In 2004, CSHNB and OHSM began to link birth certificate files and newborn screening files on an annual basis. The data for the Newborn Metabolic and Hearing Screening Programs are linked at CSHNB, and the linked database is provided to OHSM. This CSHNB database is linked with the birth certificate files at OHSM, then sent to CSHNB along with selected demographic variables for analysis with an average linkage rate of 99.8%.

With the receipt of the AG's opinion, the WIC program piloted linkage between birth certificate files and selected WIC data elements in 2005. A 92% match rate was achieved for clients born in 2003. This pilot project established the technical possibility of linking birth records with WIC data, however, procedures need to be developed to create this linked data on a regular basis.

Discussions with the Department of Human Services Med-QUEST Division (MQD) have taken place sporadically since 2002 regarding linkage of birth certificate and Medicaid files. A major challenge has been the turnover of 4 MQD administrators in 5 years. In 2006 MQD and OHSM were able to initiate a project to verify whether Medicaid applicants/enrollees had Hawaii birth certificates to document U.S. citizenship/legal immigrant status as mandated by the federal Deficit Reduction Act. OHSM is willing to pursue actual linkage of birth certificates with Medicaid records, but serious administrative barriers have emerged during the verification process (see discussion in HSCI 5A). Title V will continue to work with OHSM to pursue the linkage.

REGISTRIES AND SURVEYS

The Hawaii Health Information Corporation (HHIC) is a private non-profit organization that maintains a database of all patient discharge records collected from Hawaii's 25 hospitals for each year since 1993. Since this database exists, hospital surveys are not necessary. The DOH is in the process of contracting with HHIC to allow 25 DOH users access to the HHIC online server to access to both hospital discharge and emergency room data. The Title V agency will likely receive one of the user memberships. The contract with HHIC is currently pending review before the AG's office and is expected to be approved soon.

Hawaii is one of a limited number of states that maintains a population-based active surveillance system for birth defects through the Hawaii Birth Defects Program (HBDP). HBDP is funded through a contract administered by the CSHNB and regular program reports are generated. The Title V program is working with HBDP on access to the HBDP data files and development of the annual report.

The MCH Branch within the Title V agency conducts the Pregnancy Risk Assessment Monitoring System (PRAMS) and has direct access to this database. The Hawaii PRAMS Project is one of 37 States nationwide that collects data on health behaviors of women shortly after pregnancy through a mail or telephone survey. Hawaii PRAMS obtained the first full year of data in 2000.

A portion of the PRAMS data for 2000-2004 is now accessible via the internet through the efforts of the DOH data warehouse. The website provides pre-designed tables/charts on many of the PRAMS survey questions, providing ready access to the data.

With the assignment of a new CDC epidemiologist to the Title V agency, activities to improve data access and analysis should advance. Don Hayes, M.D. M.P.H. will begin work in July 2007. His position will be Title V funded. SSDI grant funds will be used to hire a new planner to assist Dr. Hayes with work on these major MCH datasets.

/2009/ Data linkage between birth certificates and WIC client files was achieved in 2007. Currently, WIC is submitting data on a quarterly basis to DOH OHSM (the vital stats office) for linking. Administrative issues are being addressed by the WIC Services Branch.

For an update on the hospital data see HSCI 5a.

Efforts to transition the Hawaii Birth Defects program from the University contractor to the Title V CSHN Branch continue. //2009//

/2010/ Direct access to State hospital discharge data was achieved in 2008 with SSDI funding. For an update on the hospital data see HSCI 5a. Work on the birth defects dataset has been slowed by the lack of staffing for the Hawaii Birth Defects Program (HBDP). HBDP transitioned from a program contracted through the Research Corporation of the University of Hawaii to a program with state-funded staff within the DOH. All 4 HBDP positions are currently vacant and are likely to be effected by a hiring freeze. The transition of the program has resulted in delayed abstracting of birth defects data from medical records, and lack of a program supervisor to lead the data analysis effort. //2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2010

Narrative:
The purpose of this measure is to assure the state Title V agency's ability to access key MCH datasets for use in policy development and program planning. Hawaii has been conducting the YRBS survey in Hawaii public schools since 1991, however, the Title V agency has not had direct access to the electronic database in the past. In 2007, direct access to the YRBS dataset is now available to select Department of Health (DOH) personnel who have received advanced training and have direct access privileges to the datasets in the DOH data warehouse.

Since 1991, the Youth Risk Behavior Survey (YRBS) has been administered every two years in the Department of Education in collaboration with the University of Hawaii (UH) and the Centers for Disease Control and Prevention (CDC). The UH's Curriculum Research & Development Group (CRDG), has been contracted to administer the YRBS in Hawaii from 1993 to the present and is the repository for the electronic dataset. Reports are generated that include the percent of adolescents' grades 9 through 12 who report using tobacco products in the past month. The Title V program is also able to request custom reports from CRDG on an as needed basis.

YRBS data has been placed into the DOH Hawaii Health Data Warehouse (HHDW). HHDW is a database of 8 DOH public health datasets available over the internet using standard commercial software for statistical analysis and reporting. Data for 2001, 2003, and 2005 Middle and High School are available in the HHDW. Due to CDC weighting standards, only some of the data is weighted. Weighted data is available for middle school for all years and only the 2005 YRBS high school data is weighted.

Currently, there are several standard report templates available for YRBS data in the HHDW, including single, multiple health indicator reports and multi-year reports. Training on use of the HHDW YRBS data system began in May 2006 and is currently limited to select Title V staff. Because the HHDW user interface requires some time to master, HHDW consultants have published a series of YRBS reports, which are available on the www.healthyhawaii2010.org web site. These pre-established reports allow Title V staff to easily access YRBS data without the need for specialized training. Through HHDW, trained Title V program staff have access to the full YRBS electronic dataset and can generate specialized reports as needed.

//2009/ The challenge for YRBS is disseminating the data in a user-friendly format to stakeholders and the general public. The School Health Survey Committee that oversees the administration of the YRBS is interested in exploring other avenues besides the HHDW to distribute YRBS data, particularly to school officials/faculty, parents, and policymakers. Hawaii is including in its Title V technical assistance (TA) request assistance to help analyze YRBS data from the Public Policy Analysis and Education Center for Middle Childhood and Adolescent Health, School of Medicine, University of California, San Francisco. The TA would also assist with development of data publications.

The Title V agency is also working on the development of an MCH databook that is utilizing YRBS data as well as data from the HSCI 9 datasets with a focus on the state Title V priority health issues. The databook will help engage more stakeholders to utilize data for planning and policy development, provide input to the Title V annual report and needs assessment. Title V's CDC-assigned epidemiologist will provide guidance for these initiatives.

The DOH Hawaii Health Data Warehouse (HHDW) focused on redesigning the project website and integrating the public reporting site and the data warehouse user site into one. The project staff also did a complete review and systems integrity testing along with updating operations manuals, training manuals, and user interface tools.//2009//

/2010/ Title V initiated discussions with the Public Policy Analysis and Education Center for Middle Childhood and Adolescent Health (CMCAH) to review YRBS data for the Title V needs assessment and for future publication. CMCAH identified issues that showed the most troubling trends and the most positive outcomes relative to national results. The analysis was used for the Title V needs assessment priority setting presentations and discussions.

Future YRBS publications will focus on developing a user-friendly "Report Card" for parents, principals/teachers, as well as fact sheets on key adolescent health issues (including state priority issues identified by the Title V needs assessment). The School Health Survey Committee is also providing input on publication ideas.

Additional epidemiology support for the project will be provided by Rebecca Shor, a two year Fellow sponsored by the Council of State & Territorial Epidemiologist. Her fellowship with the Title V agency begins in August 2009. However, Ms. Shor has been on contract with the Title V agency during Spring 2009 to provide analytical support. She also helped resolve technical issues related to accessing the YRBS dataset directly from the Data Warehouse. Her contract has been funded by the SSDI grant. //2010//

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 and categorized 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 may vary among States (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 each individual performance measure;

2) by having budgeted and expended dollars spread over all four of the recognized MCH services: direct health care, enabling services, population-based services, and infrastructure building services; and

3) by having a positive impact on the outcome measures.

Based on a five year needs assessment, the State Title V agency identifies up to 10 priority health issues of unique concern to the State that may not normally be addressed by the national performance measures. A state performance measure is identified for each state health priority. The State may revise its priorities based on the results of on-going needs assessment or the mandated 5-year needs assessment. Form 11 lists the current 10 state measures with data for the reporting year. Like the national performance measures, narrative reports are also presented for these state measures.

The completion of the five-year needs assessment in this year's FY 2006 application resulted in the deletion of several measures and addition of new measures. Detail sheets for the new state performance measures are in Form 16.

In FY 2004 report, Hawaii met or exceeded its Annual Performance Objectives for 5 of the 12 National Performance Measures (the 5 Children with Special Needs measures that rely on the national CSHN survey were excluded and PM 13 that had no data to report this year) and met or exceeded its Annual Performance Objectives for 5 of the 9 State Performance Measures (no 2004 data for SPM 03). Hawaii met or exceeded 6.3 Healthy People 2010 objectives for measures with numerical targets and contributed to meeting 5 HP 2010 objectives without numerical targets.
/2007/ In the FY 2005 report, Hawaii met or exceeded its Annual Performance Objectives for 7 of the 10 National Performance Measures where objectives were set (The 5 Children with Special Needs measures that rely on the national CSHN survey were excluded and 3 NPMs are new this year). When final data becomes available for 2005, objectives will be evaluated for possible revision. //2007//
/2008/ In the FY 2006 report, Hawaii met or exceeded its Annual Performance Objectives for 8 of the 9 National Performance Measures where objectives were set and data was available (The 5 Children with Special Needs measures that rely on the national CSHN survey were excluded; the 2 new NPMs did not have current data to compare with the 2006 objective, and 2 NPMs are 3 year moving averages, thus do not have current data). When final data becomes available for 2006, objectives will be evaluated for possible revision. //2008//
/2009/ In the FY 2007 report, Hawaii met or exceeded its Annual Performance Objectives for 5 of the 11 National Performance Measures where objectives were set and data was available (The 5 Children with Special Needs measures that rely on the national CSHN survey were excluded and 2 NPMs are 3 year moving averages, thus do not have current data). When final data becomes available for 2007, objectives will be evaluated for possible revision.//2009//
/2010/ In the FY 2008 report, Hawaii met or exceeded its Annual Performance Objectives for 1 of the 8 National Performance Measures where objectives were set and data was available (The 5 Children with Special Needs measures that rely on the national CSHN survey were excluded and 5 NPMs did not have current data). When final data becomes available for 2008, objectives will be evaluated for possible revision.//2010//

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 each State to meet its performance goals and 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.

B. State Priorities

Ten priority issues were identified through the 2000 Maternal and Child Health five year needs assessment. These priorities are the programmatic focus areas for FHSD working in partnership with other agencies/programs through 2010. Each priority is described in relationship to National and State performance measures used to track them. 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.

1. REDUCE ADULT (PARENTS, PREGNANT WOMEN) & ADOLESCENT SUBSTANCE ABUSE.
The performance measures related to this priority are:
SPM 3 The percent of women who report use of alcohol, tobacco, and other drugs during pregnancy.
SPM 5 The percent of teenagers in grades 9 to 12 attending public schools who report smoking tobacco within the last 30 days.

2. REDUCE FAMILY VIOLENCE AND CHILD MALTREATMENT.
The performance measures related to this priority are:
NP 16 The rate (per 100,000) of suicide deaths among youths 15-19.

SPM 7 Rate of confirmed child abuse/neglect reports per 1,000 for children aged 0-5 years.
SPM 8 Percent of teenagers in grades 9 to 12 attending public schools who report being involved in a physical fight within the last 12 months.

3. 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 11 The percent of pregnancies (live births, fetal deaths, abortions) that are unintended.

4. IMPROVE THE DENTAL HEALTH OF CHILDREN
The performance measure related to this priority is:
NPM 9 The percent of 3rd grade children who have received protective sealants on at least one permanent molar tooth.

5. REDUCE OVERWEIGHT AND OBESITY IN CHILDREN
The performance measure related to this priority is:
SPM 13 The percent of teenagers in grades 9 to 12 attending public schools that are overweight.

6. IMPROVE ACCESS TO HEALTH CARE
The performance measures related to this priority are:
NPM 1 The percent of newborns who are screened and confirmed with conditions mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) and who receive appropriate follow up and as defined by their State.
NPM 3 The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.
NPM 4 The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.
NPM 5 The percent of children with special health care needs age 0 to 18 whose families report the community-based service system are organized so they can use them easily.
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.
NPM 7 Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.
NPM 9 Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
NPM 13 Percent of children without health insurance.
NPM 14 Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.
NPM 17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
NPM 18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
SPM 12 Percent of infants with hearing loss who are receiving appropriate intervention services by age 6 months.
SPM 16 Percent of children aged 0-3 years who are developmentally delayed, or biologically or environmentally at risk who receive early intervention services to meet needs specified in the Individual Family Support Plan.

7. ENSURE THAT ALL CHILDREN 0-3 YEARS WHO ARE DEVELOPMENTALLY DELAYED, OR BIOLOGICALLY OR ENVIRONMENTALLY AT-RISK RECEIVE NEEDED EARLY INTERVENTION SERVICES.
The performance measure related to this priority is:
SPM 16 Percent of children aged 0-3 years who are developmentally delayed, or biologically or environmentally at risk who receive early intervention services to meet needs specified in the Individual Family Support Plan.

8. ENSURE THAT ALL INFANTS AND CHILDREN RECEIVE APPROPRIATE AND TIMELY HEARING EVALUATION AND EARLY INTERVENTION SERVICES.
The performance measures related to this priority are:
NPM 12 Percentage of newborns who have been screened for hearing before hospital discharge.
SPM 12 Percent of infants with hearing loss who are receiving appropriate intervention services by age 6 months.

9. ASSURE THAT PARENTING SUPPORT AND INFORMATION IS MADE AVAILABLE TO ALL FAMILIES WITH CHILDREN.
The performance measure related to this priority is:
SPM 14 The percent of families assessed to be at risk for child maltreatment that enroll in Hawai`i Healthy Start home visiting support services.

10. IMPROVE ASSESSMENT AND SURVEILLANCE OF MCH POPULATIONS, INCLUDING CHILDREN WITH SPECIAL HEALTH CARE NEEDS.
The performance measure related to this priority is:
SPM 15 Degree to which the MCH agency performs ten essential public health functions, as measured on a scale from 0-30.

/2007/ Nine priority issues were identified through the 2005 Maternal and Child Health five year needs assessment. Three priorities are continuing from the 2000 needs assessment (unintended pregnancy, hearing intervention services, and child overweight). These priorities are the programmatic focus areas for FHSD working in partnership with other agencies/programs through 2010. Each priority is described in relationship to National and State performance measures used to track them. 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.

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.

2. ENSURE THAT ALL INFANTS AND CHILDREN RECEIVE APPROPRIATE AND TIMELY HEARING EVALUATION AND EARLY INTERVENTION SERVICES.
The performance measures related to this priority are:
NPM 12 Percentage of newborns who have been screened for hearing before hospital discharge.
SPM 2 Percent of infants with hearing loss who are receiving appropriate intervention services by age 6 months.

3. REDUCE OVERWEIGHT AND OBESITY IN CHILDREN
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.
SPM 3 The percent of teenagers in grades 9 to 12 attending public schools that are overweight.

4. PREVENT UNDERAGE DRINKING AMONG ADOLESCENTS
The performance measure related to this priority is:
SPM 4 Percent of teenagers in grades 6 to 8 attending public schools who report drinking alcohol within the past 30 days.

5. IMPROVE THE ORAL HEALTH OF CHILDREN
The performance measure related to this priority is:
NPM 9 Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

SPM 5 Proportion of children aged 6 to 8 years with dental caries experience in their primary and permanent teeth.

6. REDUCE THE RATE OF ADOLESCENT CHLAMYDIA
The performance measure related to this priority is:
SPM 6 The rate of women aged 15-19 years (per 1,000) with a reported case of chlamydia.

7. INCREASE ABSTINENCE FROM ALCOHOL USE DURING PREGNANCY
The performance measure related to this priority is:
SPM 8 Percent of women who report use of alcohol during pregnancy.

8. INCREASE ABSTINENCE FROM SMOKING DURING PREGNANCY
The performance measure related to this priority is:
NPM 15 Percentage of women who smoke in the last three months of pregnancy.
SPM 7 Percent of women who report smoking tobacco during pregnancy.

9. IMPROVE TRANSITION SERVICES TO ADULT LIFE FOR YOUTH WITH SPECIAL HEALTH CARE NEEDS
The performance measure related to this priority is:
SPM 9 Degree to which state activities support the transition of youth with special health care needs to adult health care, work, and independence. //2007//

/2008/ There was no change to the state MCH priorities. //2008//

/2009/ There was no change to the state MCH priorities. //2009//

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	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	9	10	11	13	19
Denominator	9	10	11	13	19
Data Source					Data Source (numerator/denominator): Hawai‘i State
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
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Since September 2003 Hawai‘i tests for 32 disorders. 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.

Notes - 2007
Data is from the State Newborn Metabolic Screening Program, Department of Health. Since September 2003 Hawai‘i tests for 32 disorders.

Notes - 2006
Data is from the State Newborn Metabolic Screening Program, Department of Health. Since September 2003 the State of Hawaii tests for 32 disorders.

a. Last Year's Accomplishments
One hundred per cent of infants who were screened positive received timely follow-up to definitive diagnosis and clinical management for conditions mandated by the State sponsored newborn screening program. The FY 2008 objective was met.

Hawaii's contracted newborn screening laboratory, the Oregon State Public Health Laboratory, started testing for cystic fibrosis (CF) for Hawaii's infants on September 1, 2007, following successful contract negotiations. NBMSP conducted extensive in-service sessions on cystic fibrosis and newborn screening in birthing facilities for physicians, nurses and laboratory staff; childbirth educators; public health nurses; midwives; and perinatal groups such as Healthy Mothers/Healthy Babies. NBMSP developed informational flyers on cystic fibrosis; revised the newborn screening parent brochure; and disseminated these statewide to health providers. NBMSP also revised the Newborn Screening Administrative Rules to include cystic fibrosis screening and to increase the newborn screening fee from $47 to $55 for each initial newborn screening specimen collection kit. NBMSP also established a nursing position to assist with short-term and long-term follow up. By adding CF screening, Hawaii is now screening for 32 disorders. Hawaii has exceeded the national newborn screening recommendations from the American College of Medical Genetics and the March of Dimes for a uniform panel of 29 disorders across all states.

NBMSP has oversight over the newborn metabolic screening system: obtaining blood specimens at hospitals, specimen transport, central laboratory testing, physician notification, and tracking. NBMSP staff tracked all infants who were diagnosed with metabolic and other disorders, had abnormal and unsatisfactory screening results, transferred to another facility, or were not screened. For infants who were confirmed with disorders, NBMSP identified the medical home, linked the medical home with the metabolic consultants, and followed-up with the medical home to ensure timely treatment.

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. The screening practice profiles and updated information on newborn metabolic screening are also provided on the Department of Health website.

Because NBMSP can no longer obtain names of home birth parents identified through birth certificate data, there is great potential for missed and/or delayed diagnosed cases in the home birth population. Packets with newborn metabolic screening and newborn hearing screening information have been distributed to birth registrars to give to home birth parents when they register their infant for a birth certificate. To increase access to newborn screening for the home births, NBMSP has been giving newborn screening specimen collection kits to midwives and naturopaths without charge.

NBMSP participated and continues to be involved in the Genetics Program's Western States Genetic Services Collaborative, which is a federally funded multi-state project that seeks to coordinate and increase access to genetic services among the participating states and territory. The participating states and territory are: Alaska, California, Guam, Hawaii, Idaho, Oregon and Washington. The project activities aim to improve the health of children with disorders detected by the newborn screening blood test, birth defects, and other genetic disorders through the use of telemedicine, improving genetic services data collection and use, newborn screening long-term follow-up data, and developing health outcome indicators for genetic services. The mission is to take a regional approach to coordination, sharing, and improving access to genetic services. Project funding is from the Health Resources and Services Administration, Maternal and Child Health (MCH) Bureau, Genetic Services Branch.

NBMSP has reported three infant deaths due to fatty acid oxidation (FAO) disorders to the Child Death Review Coordinator. FAO disorders are known to cause 4-5% of the Sudden Unexplained Infant Death (SUID) cases, which might otherwise be labeled as SIDS. It is hoped that newborn screening results will be incorporated as part of the protocol in the investigation of SUID cases.

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 screening 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	X

b. Current Activities

NBMSP continues its oversight over the newborn screening system and continues to send out monthly screening practice profiles to all the birthing facilities.

NBMSP continues to commit $50,000/year of its special funds to support Hawaii Community Genetics for follow-up services for metabolic disorders and $25,000/year of its special funds to support the Hemoglobinopathy Clinic. CSHNB continues to contribute the services of genetic counselors several days per week, as well as services from the metabolic nutritionist and NBMSP coordinator.

To improve the services at the Hemoglobinopathy Clinic, NBMSP has contracted for confirmatory DNA alpha thalassemia testing. This information has been very helpful to the hematologist, geneticist, and genetic counselors to give improved genetic counseling services to families.

To increase access to newborn screening for home births, NBMSP continues to give newborn screening kits to midwives and naturopaths without charge.

NBMSP is now participating in a Genetics Program's multi-state Newborn Screening False Positives Project, which is a Maternal and Child Health Discretionary Grant. This project seeks to use current evidence, resources, and parental input to provide the structure for the development of model educational materials and resources for parents from diverse backgrounds to aid the understanding of false positive results in newborn screening. The collaborating states are Alaska, California, Hawaii, Idaho, Oregon, and Washington.

c. Plan for the Coming Year

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

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 try to get these infants screened. NBMSP staff will also continue to provide education to health care providers, midwives, public health nurses, childbirth educators, and the general public about expanded newborn metabolic screening. NBMSP will utilize the Perinatal Advocacy Network, coordinated by Healthy Mothers/Healthy Babies Coalition, to disseminate information. More medical in-service sessions will be conducted to give feedback to the physicians regarding the findings of the expanded newborn screening program. Efforts will also be made to do more in-service education sessions with prenatal providers on expanded newborn screening testing, as mothers have clearly expressed the desire to learn about newborn metabolic screening from their prenatal care providers. NBMSP will also continue to provide more updated information on newborn metabolic screening on the websites.

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. NBMSP is also assisting each birthing facility to improve the quality of their newborn screening specimens by giving immediate feedback on possible reasons for the unsatisfactory specimens.

In addition, NBMSP will need to start 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 the Genetics Program's multi-state HRSA Western States Genetic Services Collaborative and Newborn Screening False Positives Project. The Genetics Program will also be applying for a two year CDC grant to develop and implement a collaborative pilot project with population-based surveillance of confirmed hemoglobinopathies of both pediatric and adult populations using the established newborn screening program and other data sources. NBMSP will participate if Hawaii is awarded this grant.

In spite of state budget cuts, NBMSP will be able to carry out current and future activities because

of sufficient funds in the NBMSP Special Fund.

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	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	52.4	52.4	52.4	52.5	59.3
Annual Indicator	52.4	52.4	52.4	59.3	59.3
Numerator	10114	10114	10114	20783	20783
Denominator	19291	19291	19291	35041	35041
Data Source					Data Source (numerator/denominator): U.S. Departme
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
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	59.3	59.3	59.3	59.3	59.3

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
Families of children with special health care needs (CSHCN) were involved in various ways, participating as council, task force, and advisory committee members; developing and reviewing parent education materials; participating in presentations and panels; interviewing applicants for staff positions; advocacy for legislation; and input on proposed changes for policies and procedures. Parents were compensated or assisted in various ways including stipends, airfare/ground transportation for Neighbor Island families, and child care during activities. Family participants were of diverse ethnic and cultural backgrounds. Family members participate on the Hawaii Early Intervention Coordination Council, Newborn Metabolic Screening Advisory Committee, Early Hearing Detection and Intervention Advisory Committee, State Genetics Advisory Committee, and other committees.

Early Intervention Section (EIS) developed a set of goals/indicators, built the capacity, and began collecting, reporting, and using data for program improvement. Goals for families included understanding child's abilities and special needs, knowing rights and effectively communicating child's needs, helping their child learn/develop, adequate social support, and accessing services/activities. Goals for children include their having social and emotional skills, learning and using knowledge and skills, and taking action to meet their needs.

The Hilopaʻa Project (Integrated Systems for CSHCN) is a collaborative project of Children with Special Health Needs Branch (CSHNB) and Family Voices, with American Academy of Pediatrics-Hawaii Chapter and University of Hawaii (UH) Department of Pediatrics, with MCH Bureau funding. Hilopaʻa Project worked to increase family participation in program and policy activities. Guidelines on Compensation for Family Participation were implemented, shared with other programs as sample, and posted on CSHNB website. Parents of CSHCN were identified and linked as community facilitators for the Medicaid Infrastructure Grant, faculty for MCH Leadership in Education in Neurodevelopmental and Related Disabilities Program (MCH LEND), core committee to develop an EI parent-to-parent network, advisory committee for nurse practitioner fellowship program, Project Trainers, DOH/Developmental Disabilities Division Statewide Advisory, and State Council on Developmental Disabilities/Health and Early Childhood Committee. The Project Co-Director participated as a member of the QUEST Advisory Council.

The Hilopaʻa Project's "Extreme Makeover" conference was held in October 2007. Attendees included family members and self-advocates from all islands. Best practices, tips, and techniques on Family Training were shared, including first-hand experiences from Family Voices of Arizona, California, Nevada, and Navajo Nation.

The Hilopaʻa Family to Family Health Information Center (F2FHIC), funded by the MCH Bureau, was established by Family Voices of Hawaii in partnership with the Hawaii Pediatric Association Research and Education Foundation. It provided information and referral, consultation, and training to families of CSHCN and their professional partners statewide. Two "veteran moms" were enlisted to provide family to family support and information. The F2FHIC posted local call numbers on all neighbor islands that were centrally connected.

Hawaii's Title V Family Trainers Academy was launched by the Hawaii MCH LEND Program, Hilopaʻa Project, and Hilopaʻa F2FHIC. This summer institute developed trainer/facilitator skills and knowledge with community based leaders and advocates from areas across the state. Course work included review of adult learning styles and application of strategies, development of training delivery skills, integration of culture and diversity into training activities, community leadership and facilitation, and specific content knowledge in navigating the system. Trainees were parents, self-advocates, youth self-advocate, and community providers from all islands, including some rural areas.

The 2008 Legislature passed a bill establishing an Autism Spectrum Disorders (ASD) Benefits and Coverage Task Force to research problems faced by parents and make recommendations to ensure proper benefits and services are provided through public and private resources to address the needs of children with ASD. CSHNB was designated to facilitate the process and report of recommendations.

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; as interviewers for staff positions; in developing and reviewing parent education materials; as trainers or presenters; etc.				X

2. Promote and support the development of family leadership and family-professional partnerships.				X
3. Promote the inclusion of family participants in program and policy activities.				X
4. Promote the compensation of family members for participation in councils, task forces, etc.				X
5. Involve/support families in advocating for policy change, including legislation.				X
6. Disseminate Hawaii data on family partnership from the National Survey of CSHCN.				X
7. Use Hawaii data on family partnership in planning/improving outcomes for CSHCN.				X
8. Provide information/training to families, providers, and programs on resources and services for CSHCN and on navigating the system of services.		X		X
9. Design and implement a Family to Family Health Information Center.		X		X
10.				

b. Current Activities
Children with Special Health Needs Program is developing a Family Handbook and Transition Planning addition to the Family Service Plan, with input from families.

The Hilopa‘a Project continues to provide trainings on Natural Supports and Transition for families and professional partners. Rainbow Book training was updated to include new QUEST information.

The Hilopa‘a F2FHIC continues to provide family to family support and information which can be accessed by families of CSHCN.

Hawaii's Title V Family Trainers Academy graduates are applying, in their community activities, strengthened facilitation skills and knowledge about child health services.

The ASD Benefits and Coverage Task Force included 3 parents of children with ASD, appointed by the Governor. The Task Force developed recommendations for health insurance coverage for ASD-related services and submitted a report to the 2009 State Legislature.

"My Voice, My Choice" is a collaborative project of the State Council on Developmental Disabilities, Hawaii Disability Rights Center, UH Center on Disability Studies, and Self-Advocacy Advisory Council. A Youth Information, Training, and Resource Center is being created to improve education and employment outcomes for youth by increasing their voice in the development of policies and services that affect their choices.

CSHNB representatives attended an Act Early Summit for Region IX. Hawaii Team members include parents of children with ASD, and an adult with ASD.

c. Plan for the Coming Year
Families will continue to be involved in various ways, including councils, task forces, and advisory committees; development and review of information materials for parents; 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.

Family Voices and the Hilopa'a F2FHIC will continue to provide trainings on Natural Supports, Transition, and the Rainbow Book, for families and professional partners. It will continue to provide family-to-family support and information which can be accessed by families of CSHCN via telephone, fax, written correspondence, email and the internet.

As part of the Title V Needs Assessment for CSHCN in 2009, survey responses from families of CSHCN and community/provider persons will be included in processes to prioritize concerns and needs, research methods and resources, and plan future initiatives and activities. CSHNB and three workgroups will further analyze Hawaii data from the National Survey of CSHCN, 2005-2006, for subgroups and comparisons.

The serious downturn in state and national economies, declining revenues and rising expenditures are resulting in large spending cutbacks in state government positions, services, and goods and services purchases. Deep spending reductions will seriously reduce Children with Special Health Needs Program services to CSHCN/families, and EIS services to children age 0-3 is being impacted. Specific actions to address funding issues are being developed. Constraints are expected to continue limiting resources extensively, well into 2010. CSHNB monitoring of changing conditions, emerging issues/resources, and advocating for CSHCN will be continuous at family and community levels.

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	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	47.9	47.9	47.9	47.9	45.2
Annual Indicator	47.9	47.9	47.9	45.2	45.2
Numerator	14657	14657	14657	15632	15632
Denominator	30627	30627	30627	34568	34568
Data Source					Data Source (numerator/denominator): U.S. Departme
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
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	45.2	45.2	45.2	45.2	45.3

Notes - 2007
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 PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The medical home concept established in Hawaii is that all children, both with and without special health care needs, should have a medical home. This has been promoted and supported by the American Academy of Pediatrics (AAP)-Hawaii Chapter, University of Hawaii (UH)/School of Medicine/Department of Pediatrics, Family Health Services Division, and other public health programs.

CSHNB incorporates the medical home into program services, through working to ensure that every child has a primary care provider, Individual Family Support Plan (IFSP) conferences include the medical home, protocols for medical specialty referrals include the medical home, etc.

The Hilopaʻa Project (Integrated Systems for CSHCN) is a collaborative project of Children with Special Health Needs Branch (CSHNB) and Family Voices, with American Academy of Pediatrics-Hawaii Chapter and UH Department of Pediatrics, with MCH Bureau funding. The Hilopaʻa Project supported the Pediatric and Family Practice Residency Curriculum which extends teaching knowledge, skills, and attributes of the Medical Home to include integrated service system roles. Sessions included Medical Home Noon Conferences with facilitators and parent representatives, and orientation to the Rainbow Book with case studies on appropriate referrals to community services.

Hilopaʻa Project promoted an integrated developmental screening and referral process. The Project developed a referral flow chart with Parents' Evaluation of Developmental Status (PEDS) and Ages and Stages Questionnaire (ASQ) as standardized screening tools. The Project provided PEDS training and the CSHNB Preschool Developmental Screening Program assisted with ASQ training for pediatric residents.

Training on the Modified Checklist for Autism in Toddlers (M-CHAT) for pediatricians was provided at a February 2008 AAP-Hawaii Chapter meeting. A team of a parent of a child with autism spectrum disorder and child psychiatrist conducted the training with Hilopaʻa Project support. The Chapter adopted a position statement to work to enable pediatric providers to perform developmental surveillance at every well-child visit and developmental screening using a standardized screening tool at 9, 18, and 24 month visits or when a concern is expressed. Recommended standardized screening tools include PEDS and ASQ.

Hilopaʻa Project provided trainings on the "Rainbow Book--A Medical Home Guide to Resources for CSHCN and Their Families," which supports understanding and accessing community-based services. Trainees were professionals of various agencies, family members, and self advocates on all islands.

The 2006 Legislature (SCR 70 HD1) established a Hawaii Childhood Screening Task Force. CSHNB, with Hilopaʻa Project support, convened the Task Force to address screening tools, referral protocols, guidelines, and physician participation issues regarding developmental, behavioral/social-emotional, hearing, and vision screening for children age 0-8 years. The report to the 2008 Legislature identified action areas, including improving vision and hearing screening for preschool/school-age children, and addressing barriers (e.g., office staffing, time, cost of tools, payment issues) to screening by primary care providers. CSHNB drafted testimonies for legislative bills related to vision and hearing screening.

Children with Special Health Needs Program (CSHNP) supports medical homes by assisting

families of CSHCN with access to services. CSHNP provides information and referral, outreach, care coordination, social work, and medical nutrition therapy for CSHCN age 0-21 years. Pediatric cardiology and/or neurology clinics are provided on the islands of Hawaii, Kauai, and Maui where services are not available. Financial assistance for medical specialty services is provided for eligible children who have no other resources.

Working with CSHNP, UH Department of Pediatrics, and Kapiolani Medical Center established a new multidisciplinary Oral Cleft Clinic. CSHNP works as clinic team members and assists families with coordinating services of various community providers. On behalf of individual children and families, CSHNP staff participate in liaison with other community based service providers, promoting continuity of care and flow of communications. In relation to community based programs, CSHNP informs public health nurses, physicians, dental specialists, speech pathologists, school counselors, etc., about this clinic.

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 programs and services.	X	X	X	X
2. Identify/address issues and barriers to service delivery, in order to support care by medical home.				X
3. Disseminate Hawaii data on medical home from the National Survey of CSHCN and National Survey of Children's Health.				X
4. Use Hawaii data on medical home in the development and implementation of plans to improve outcomes for CSHCN.				X
5. Identify best practices, protocols, and standards for referral and transition between various state and community agencies.				X
6. Provide training which includes a medical home component, to programs, agencies, providers and families on navigating the system and on best practices, protocols, and standards for referral and transition.				X
7. Support implementation of a Pediatric and Family Practice Residency Curriculum which extends teaching knowledge, skills, and attributes of the Medical Home to include integrated service system roles.				X
8. Promote developmental screening and follow-up. Provide trainings to physicians and programs/agencies statewide on the PEDS and ASQ screening tool and integrated referral process.				X
9. 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 this clinic.		X		
10.				

b. Current Activities

Hilopa'a Project continued its trainings on the "Rainbow Book--A Medical Home Guide to Resources for CSHCN and Their Families" and developmental screening.

The Department of Human Services and contractors implemented the change from Medicaid fee-for-service to QUEST Expanded Access (QUEST ExA) managed care, for aged, blind, and disabled beneficiaries. Service coordination is a required component for the health plans. This should increase service coordination and comprehensive care through primary care providers and medical homes.

CSHNP is providing consultation, guidelines, and training to assist the Lions Club in a vision and hearing screening project in schools. CSHNP and Preschool Developmental Screening Program have provided input to two projects funded by Aloha United Way to screen preschool age children in two underserved communities. These projects will refer a proportion of children to their medical homes for evaluation and care.

Working with CSHNP, the UH Department of Pediatrics and Kapiolani Medical Center's newly established multidisciplinary Oral Cleft Clinic is expanding its clinic sessions, staffing, and age ranges served. Recently renamed the Cleft and Craniofacial Clinic, this is the only team service for Hawaii's civilian children/families. CSHNP assists families with coordinating services of various community providers. CSHNP is providing information on this clinic to the public health nurses and other programs.

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.

CSHNB programs will continue to promote the medical home concept in various planning efforts and program services.

CSHNP will continue to support the medical home by assisting families with access to services, through addressing financial access and assisting Neighbor Island children to obtain medical specialty services.

CSHNP will continue to work with UH Department of Pediatrics and Kapiolani Medical Center on the Cleft and Craniofacial Clinic. The clinic provides coordinated, comprehensive services for children with craniofacial disorders with complex medical needs.

CSHNB and other Early Childhood Comprehensive Systems (ECCS) partners will continue work toward achieving the Hawaii ECCS Plan outcome that all children will have access to and receive preventive and ongoing regular care.

The State Council on Developmental Disabilities continues its effort toward a goal that family-centered, community-based, culturally-appropriate services and supports will be available to all CSHCN, with an objective to "Improve community support services for children with developmental needs and their families". An activity is to "Encourage efforts to assure a medical home for every young child with developmental disabilities." CSHNB and Family Voices representatives are on this committee.

CSHNB Issues Teams will continue assessment, plan development, and activities promoting early detection and coordinated, comprehensive care for more cost effective interventions.

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	**2004**	**2005**	**2006**	**2007**	**2008**

Annual Performance Objective	70.2	70.2	70.2	70.2	73.5
Annual Indicator	70.2	70.2	70.2	73.5	73.5
Numerator	21980	21980	21980	26078	26078
Denominator	31318	31318	31318	35459	35459
Data Source					Data Source (numerator/denominator): U.S. Departme
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
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	73.5	73.5	73.5	73.5	73.5

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
Children with Special Health Needs Program (CSHNP) care coordinators/program staff provided information and assisted uninsured children with special health care needs (CSHCN) and their families in obtaining and maximizing use of health coverage from public and other sources. As a safety net and to increase access to services, CSHNP provided 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 is administering the Hawaii Lions Foundation Uninsured/Under-Insured Fund for hearing and vision services.

Newborn Metabolic and Newborn Hearing Screening Programs provided screening and diagnostic evaluations for families who cannot afford the cost.

Preschool Development Screening Program provided developmental and behavioral screening for children and assisted with follow-up for concerns. Services were provided at no out-of-pocket cost to parents.

Early Intervention Section (EIS), with Healthy Start and Public Health Nursing Branch, provided early intervention services for children age 0-3 with or at biological/environmental risk for developmental delays, as mandated by Part C of the Individuals with Disabilities Education Act. 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 to services; and vision services. Early intervention services for QUEST-eligible

children are reimbursed through a Memorandum of Agreement between the Department of Human Services (DHS) and the DOH.

EIS administers the DOH respite funding for children age 0-3 years with developmental delays and children/youth age 0-21 years with serious/chronic illness.

Hawaii Covering Kids continued efforts to find, enroll, and retain eligible children and youth in health insurance programs. In collaborates with federal, state, and community agencies, it conducts outreach activities and helps Med-QUEST simplify its processes.

DHS raised QUEST and Medicaid fee-for-service income eligibility levels up to 300% of the federal poverty level. Premium payments for children in households between 251-300% FPL (QUEST-Net) were eliminated.

Keiki Care was a new program developed by Hawaii Medical Service Association and the State to provide only basic health care coverage for uninsured children age 31 days through 18 years, who were not eligible for other state or federal coverage. The program was discontinued by the State DHS after a few months and HMSA announced it would continue it until December 2008 and explore alternatives.

DHS issued its Request for Proposal for QExA capitated managed care plans to cover eligible individuals who are the Aged, Blind, and Disabled (ABD), including children in the Medically Fragile Community Care Program. The program provides for a comprehensive package of medical, dental, long-term care, and behavioral health. Services were projected to begin November 2008, but were postponed until 2009.

Children with Special Health Needs Branch (CSHNB), Family Voices, American Academy of Pediatrics (AAP)-Hawaii Chapter, and University of Hawaii (UH)/School of Medicine/Department of Pediatrics, with Maternal and Child Health (MCH) Bureau funding, implemented the Hilopa‘a Project-Integrated Systems for CSHCN. The Hilopa‘a Project assisted DHS in developing a Request for Information (RFI) on converting ABD beneficiaries to managed care. The RFI introduced the medical home concept as standard not only for children but for adults with special health care needs, through inclusion of a goal to assure coordination of care and decrease care fragmentation across the benefit continuum including primary, acute, behavioral health, and long-term care benefits.

The 2008 Legislature passed a bill establishing an Autism Spectrum Disorders (ASD) Benefits and Coverage Task Force to research problems faced by parents and make recommendations to ensure proper benefits and services are provided through public and private resources to address the needs of children with ASD. CSHNB was designated to facilitate the process and report of recommendations.

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, e.g., SSI, Medicaid waivers.		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 legislative and other efforts to improve insurance				X

coverage or services when family needs are not met.				
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 in developing and/or implementing plans to improve outcomes for CSHCN.				X
8. Provide training which includes a health insurance component, to programs, agencies, providers and families on navigating the system and on best practices, protocols, and standards for referral and transition				X
9.				
10.				

b. Current Activities
Hilopa'a Project continued its trainings on "The Rainbow Book--A Medical Home Guide to Resources for CSHCN and their Families", which include Medicaid/QUEST update, Supplemental Security Income, and TRICARE for military families. Trainings are for professionals, family members, and self advocates on all islands. The project continues to assist DHS as needed regarding outreach or information to families.

Hawaii Medical Services Association is offering a plan for QUEST-Net Members program for individuals previously enrolled in QUEST or Medicaid Fee-For-Service, who become ineligible due to income or assets. Children under age 19 in QUEST-Net receive the same benefits as in QUEST.

The 2009 Report to the Legislature from the ASD Benefits and Coverage Task Force included findings on problems faced by parents, information from other states on insurance, and recommendations for health insurance coverage for ASD-related services in Hawaii. The State Auditor is now conducting an assessment of the social and financial impacts of mandating insurance coverage for the diagnosis and treatment of ASD.

CSHNB/Early Intervention Section researched insurance coverage for early intervention (EI) services in other states, drafted a legislative proposal to mandate coverage for EI services, and discussed it with the Hawaii Early Intervention Coordinating Council. The bill was not introduced to the state legislature, but may be considered in future years.

c. Plan for the Coming Year
CSHNB programs will continue direct and enabling services as a safety net, and coordinate and facilitate activities and communications to increase access to services for the uninsured and underinsured. Services include medical specialty and other services, newborn screening and follow-up, diagnostic evaluation, developmental and behavioral screening, and early intervention services. Staff will continue to provide information and assist uninsured families in obtaining Medicaid/QUEST and/or other health care coverage. Staff will also provide information about QExA managed care plans and about the HMSA QUEST Net plan.

The National Survey of CSHCN 2005-2006, US Census, and other data will be studied further for comparative reviews and planning purposes. Insurance concerns will be addressed as related to issues of access to specialty care, developmental screening applications with young children, and special health needs youth transitions to adult health care. CSHCN families and community providers indicate out-of-pocket costs were priority areas of concern. Families indicate CSHCN have conditions that cause financial problems for the family. These will be explored as community as well as individual concerns.

Services and service planning will include Information and education about health plans, consumer utilization, self advocacy, and resources. Staff will continue to provide information and

assist families in understanding economy of preventive practices and incentives in maintaining optimal conditions for overall health and functioning.

CSHNB will provide information as needed in ASD-related meetings on the ASD Benefits and Coverage Task Force 2009 legislative report.

Family Health Services Division, CSHNB, and EIS will continue to examine approaches regarding early intervention services, and a possible way to increase other funding sources, methods, and resources.

Using Hawaii data from the National Survey of CSHCN, 2005-2006, CSHNB placed a fact sheet with outcomes for CSHCN on the CSHNB website. As needed, CSHNB will further analyze data for subgroups and comparisons.

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	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	69.2	69.2	69.2	69.2	88.8
Annual Indicator	69.2	69.2	69.2	88.8	88.8
Numerator	13319	13319	13319	31708	31708
Denominator	19257	19257	19257	35713	35713
Data Source					Data Source (numerator/denominator): U.S. Departme
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
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	88.8	88.8	88.8	88.8	88.8

Notes - 2007
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 PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments

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

- Early Intervention Section (EIS) is the lead for Part C of the Individuals with Disabilities Education Act (IDEA) for early intervention (EI) services for children age 0-3 years with or at risk for developmental delays. The EI service system includes a 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, outreach for children with Supplemental Security Income (SSI), and other services as a safety net and to increase access to services. CSHNP now provides tele-nutrition services to Neighbor Island families.
- Genetics Program and state/community partners work to assure the availability and accessibility of quality genetic services in the state.
- Preschool Developmental Screening Program contributes to the availability of developmental screening and follow-up services for children age 3-5 years.

CSHNB, Family Voices, American Academy of Pediatrics-Hawaii Chapter and University of Hawaii (UH)/School of Medicine/Department of Pediatrics, with Maternal and Child Health (MCH) Bureau funding, implemented the Hilopa‘a Project--Integrated Systems for Children with Special Health Care Needs (CSHCN). Activities included developing the Rainbow Book to serve as an integrated system care coordination and transition guide. The guide includes programs and services for early child development, health, developmental disability, neurotrauma, behavioral/mental health, Medicaid/QUEST, SSI, family support, advocacy, military health care, and transition.

Hawaii Community Genetics is a partnership of CSHNB Genetics Program, Kapiolani Medical Center, Queen's Medical Center, and UH School of Medicine/Department of Pediatrics to provide clinical genetics/metabolic services. Genetic services have expanded with a full time geneticist for clinical services, hemoglobinopathy clinic, neighbor island clinics, and telemedicine visits.

The Genetics Program's Sickle Cell Disease Project developed a sickle cell disease and trait protocol, education materials and training, and implemented clinical services based on assessment of available services/resources and input from community-based project partners. This provides for standardized Sickle Cell Disease/Trait follow-up services, including culturally appropriate counseling for newborns in Hawaii.

Neurotrauma Supports, in the DOH/Developmental Disabilities Division, addresses the needs of people with neurotrauma injury and their families. Activities include maintaining a statewide telephone Helpline for information and referral, assisting neurotrauma injury survivors and their families to identify and access services, providing educational and public awareness, needs assessment, 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 the prevention, identification, surveillance, and treatment of FASD. CSHNP is a member of the Task Force. The FASD program offered training for FHSD staff, providers, and community programs. A pediatric geneticist presented examples showing characteristic features in offspring affected by maternal

ingestion of alcohol during pregnancy, outcomes for affected individuals, and diagnosis of FASD.

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. Advocate/work toward increasing resources to meet increased need or gaps in available services.				X
4. Provide education/training on services/resources for CSHCN.				X
5. Establish and maintain collaborative partnerships to address improving outcomes for CSHCN.				X
6. Disseminate Hawaii data on services system issues from the National Survey of CSHCN and National Survey of Children's Health.				X
7. Use Hawaii data on organization of services in needs assessment and planning toward improving outcomes for CSHCN.				X
8. Obtain information and provide training on community resources and navigating the system of services.				X
9.				
10.				

b. Current Activities

CSHNB programs continue to increase access to services and support coordination of health, social, and other services.

Hilopa'a Project provides trainings on the "Rainbow Book--A Medical Home Guide to Resources for CSHCN and Their Families", which promotes navigating and accessing community-based services. Trainings are for staff from various state/community agencies, family members, and self advocates on all islands.

Western States Genetic Services Collaborative (WSGSC) is implementing Practice Model evaluation tools; expanding neighbor island clinics and telemedicine; translating newborn screening fact sheets into Spanish; and increasing family participation in WSGSC. Sickle Cell Disease (SCD) Project protocol was developed and training provided for primary care providers with families with SCD/Trait.

The FASD program is offering FASD training for FHSD staff, providers, and community programs, "Techniques for Optimizing Success in Our System of Care: Identifying and Working with Individuals with Fetal Alcohol Spectrum Disorders."

Using Hawaii data from the National Survey of CSHCN, 2005-2006 and responses collected from CSHCN families and community providers, work groups are examining issues and needs in the areas of adequate access to specialty services on neighbor islands, identification of children with developmental delay, and transition of youth with special health care needs to adult health care.

c. Plan for the Coming Year

CSHNB programs will continue to provide services as a safety net for CSHCN and increase access to services, work toward increasing resources to meet increased need or gaps in available services, provide education/training, promote family consultation to programs, and improve coordination of health, education, social, and other services for CSHCN.

Although the Hilopa‘a Project ended in April 2009, the Family Voices State Coordinator, with the Hilopa‘a Family to Family Health Information Center, will continue to provide Rainbow Book training/certification for programs, agencies, and providers on best practices for referral and transition for state/community programs.

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

Neurotrauma Supports will continue to address the needs of people with neurotrauma injury and their families. The DOH will focus efforts in assisting individuals with neurotrauma in accessing needed services through the Department of Human Services QUEST Expanded Access. Staff will continue working on creating a neurotrauma registry and promoting education/awareness of neurotrauma.

WSGSC will continue Practice Model expansion in the western region, have satisfaction surveys to adjust the Practice Model activities, and maximize efficacy of outreach and telemedicine services. Families served via the Practice Model will be mapped over time by GIS and patient zip code to determine increasing access. The collaborative will increase participation with medical home and MCH Leadership in Education in Neurodevelopmental and Related Disabilities Program (MCH LEND) representatives. Resources and activities to collect long-term follow-up data for newborn screening will be determined.

In April 2009, as part of the Title V Needs Assessment, CSHNB conducted a statewide survey of 535 health care providers, advocates, and families with CSHCN to identify the biggest challenges for CSHCN in Hawaii. Using these survey results, in addition to Hawaii data from the National Survey of CSHCN, 2005-2006, CSHCN work groups will continue to examine issues and needs in the areas of inadequate access to specialty services on neighbor islands, underidentification of children age 0-5 years with developmental delay, and transition of youth with special health care needs to adult health care. The workgroups will be using their problem analyses of the issues to identify strategies and action steps.

See also National/State Performance Measures on screening, medical home, insurance, and transition for other system-building activities.

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	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	5.1	5.1	5.1	5.1	39.4
Annual Indicator	5.1	5.1	5.1	39.4	39.4
Numerator	351	351	351	5024	5024
Denominator	6937	6937	6937	12766	12766

Data Source					Data Source (numerator/denominator): U.S. Departme
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
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	39.4	39.4	39.4	39.4	39.4

Notes - 2007
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 PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The foundation for transition begins in early childhood. The Children with Special Health Needs Branch (CSHNB)/Early Intervention Section (EIS) provides transition planning and support for children with developmental delays exiting from early intervention (EI) services. EIS transition activities include Transition Plans, Transition Conferences, and Transition Notices in compliance with requirements of Part C of Individuals with Disability Education Act (IDEA).

The 2007 Hawaii State Legislature established the Hawaii 3-5 Transition Task Force to study the feasibility of expanding EI services for children age 3-5 years. In Oct.-Nov. 2007, families of children in DOE preschool special education were surveyed. Most families felt positively about their EI, DOE preschool, and transition experiences, and were satisfied with their child's transition to DOE preschool. The Task Force recommended follow-up of survey results by Hawaii Early Intervention Coordinating Council, Special Education Advisory Council, and STEPS (Sequenced Transition to Education in Public Schools) team. CSHNB completed the legislative and survey reports.

All DOE high school students, whether they are in special education or not, are required to begin developing a personal transition plan, beginning in the 9th grade. DOE students age 16 years and older in special education have an Individualized Education Plan (IEP) that includes coordinated goals and transition services that will enable the student to meet post-secondary goals.

Successful Transitions in Diverse Environments (STRIDE) Mentoring Project developed a vocational rehabilitation model for mentoring culturally-diverse youth and young adults with disabilities as they transition into meaningful community environments, post-secondary education or employment. CSHNB is a member of the STRIDE Advisory Board.

Hawaii Foster Parent Association Conference featured Transitioning sessions. The Youth Coalition sponsored a conference on Independent Living. The Department of Human Services

(DHS)/Independent Living Program teaches foster youth to develop skills/knowledge to function independently.

State Council on Developmental Disabilities produced a DVD featuring 6 self-advocates talking about their youth experiences, to increase disability awareness for high school students.

Hawaii Family Support 360 Project designed and implemented a Navigational One Stop System for youth age 14-21 years with a developmental disability transitioning to adulthood. Workshop academies included topics on power of attorney, guardianship, special needs trusts, career planning, IDEA, and natural supports.

A DOH Neurotrauma Help Line was established to assist individuals and families to access information and services through screening, intake, and information/referral for community services. A Neurotrauma Advisory Board subcommittee is marketing the Help Line; producing a bus placard; developing a flyer for pharmacies, physician offices, and churches, and translating it into different languages; and developing a neurotrauma resource guide.

"My Voice, My Choice" is a project of the State Council on Developmental Disabilities, Hawaii Disability Rights Center, University of Hawaii (UH) Center on Disability Studies, and Self-Advocacy Advisory Council. A Youth Information, Training, and Resource Center is being created to improve education and employment outcomes for youth by increasing their voice in the development of policies and services that affect their choices.

Children with Special Health Needs Program (CSHNP) social workers and other health professionals continued to provide outreach services to medically eligible Supplemental Security Income (SSI) applicants less than 16 years of age referred by DHS/Disability Determination Branch. Hilopa'a Project training on the Transition Planning Workbook helped guide CSHNP staff in discussing plans with families.

CSHNB and Family Voices, with American Academy of Pediatrics-Hawaii Chapter and UH Department of Pediatrics, with MCH Bureau funding, implemented the Hilopa‘a Project-Integrated Systems for CSHCN. Activities include training on the Rainbow Book with information on state/community resources for transition, developing a Transition Planning Workbook and training for families and service coordinators, providing information at family/professional conferences, and discussing transition with family and pediatric-internal medicine physicians.

See also State Performance Measure #9.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide training/information on transition planning and support for children 0-3 exiting from Part C services to other settings including the preschool special education.		X		X
2. Provide transition planning and support as children/youth exit program services to other settings/services		X		X
3. Provide information and assist children/youth/families in accessing public resources, e.g. SSI or DD/MR waiver.		X		
4. Provide outreach to SSI/medically eligible children under 16 referred by Disability Determination Branch.		X		
5. Provide training/information on strategies for successful transition, including work, independence, and adult health care.				X
6. Participate and coordinate with other transition				X

services/projects in community.				
7. Disseminate Hawaii data on transition from the National Survey of CSHCN and National Survey of Children's Health.				X
8. Use Hawaii data on transition in planning/improving outcomes for CSHCN.				X
9.				
10.				

b. Current Activities
Hilopa'a Project transition activities include Rainbow Book training with information on state/community resources, training on the Transition Planning Workbook for families and service coordinators, and provision of information on transition at family/professional conferences and trainings.

CSHNP staff is piloting their Individual Service Plans (ISP) with families. The ISP identifies family needs and services provided, and will integrate transition planning. Tools have been developed to foster discussion and to assist with data collection. Increasing staff knowledge regarding transition issues is ongoing via training.

Hawaii Family Support 360 Project continued Workshop Academies for young adults with disabilities and their parents, with speakers sharing information on identifying and obtaining services. Project strategies are key community partnerships through an advisory council, development of a certification process to ensure a streamlined service system, and a RealChoices website as part of the information/referral system that tracks services obtained by members of pilot families.

DOH Neurotrauma partnered with the UH Pacific Basin Rehabilitation Research and Training Center to implement a peer mentoring project to train mentors and have them assist persons with TBI to seek/use social services. The Neurotrauma website includes updated information and a quarterly newsletter. A current focus is to assist individuals to access needed services through QUEST Expanded Access.

c. Plan for the Coming Year
EIS continues to support the smooth transition of children exiting from EI services by convening a transition conference with families, staff, and providers at least 90 days prior to the third birthday to discuss any services that the child may receive; notifying the DOE of children who may be eligible for DOE preschool special education services; and offering families the opportunity to visit the preschool class before enrolling.

DOE Special Education Branch will continue to address transition indicators in its Part B Six Year State Performance Plan (2005-2010). Indicators include % youth with IEPs graduating from public high schools with a regular diploma, % youth age 16 and above with an IEP that includes annual IEP goals and transition services to enable the student to meet post-secondary goals, and % youth who had IEPs and have been competitively employed and/or enrolled in a post-secondary school within 1 year after high school.

The STRIDE Mentoring Project will continue to orient/train mentors, link mentors with mentees, and support mentoring pairs with monthly trainings, events/activities, and opportunities to meet people in various jobs. Young adults age 16-26, who receive services from Vocational Rehabilitation, are coached to develop and improve self-confidence, community integration, work skills, self-determination and decision-making.

The State Council on Developmental Disabilities continues its effort toward a goal that family-centered, community-based, culturally-appropriate services and supports will be available to all

children with special needs, with an objective that "Transition between early intervention services and special education preschool and between preschool and kindergarten will be a positive experience for children and families". Activities include monitoring a transition survey on an annual basis, and seeking ways to improve transition.

CSHNP policy and procedures will be revised to incorporate ISP and Transition Planning (at least by age 14) as standard practice for every child. With the ISP in place, CSHNP hopes to increase collaborations with families and with other agencies, so that youth and their families have smooth and successful transitions.

CSHNP social workers and other professional staff will continue to provide outreach to medically eligible SSI applicants referred by Disability Determination Services, and to SSI beneficiaries referred by other community resources.

Although the Hilopa‘a Project ended in April 2009, the Family Voices State Coordinator, with the Hilopa‘a Family to Family Health Information Center, will continue to provide Rainbow Book and Transition Workbook trainings for programs, agencies, and providers.

Using Hawaii data from the National Survey of CSHCN, 2005-2006, CSHNB placed a fact sheet with outcomes for CSHCN on the CSHNB website. As needed, CSHNB will further analyze data for subgroups and comparisons.

See also State Performance Measure #9.

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	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	77.9	78.3	78.6	84.8	86.6
Annual Indicator	81.2	80.1	80.1	87.8	78.2
Numerator					
Denominator					
Data Source					Data Source (numerator, denominator): U.S. Departm
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
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	88.3	90	91.7	92.4	92.4

Notes - 2008

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.

Notes - 2007
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 annual performance objectives have been modified to meet 90% by 2010. Subsequent objectives were set to increase at the same increment annually.

Notes - 2006
The annual performance objectives have been modified. An annual pace has been blueprinted to meet the Healthy People 2010 objective for this measure.

Data for FY 2000-2002 was revised to conform to the Title V measure tracking immunizations for infants 19 to 35 months. Previously, data was reported for infants up to 2 years of age.

Data changed to standard calender year reporting periods.

a. Last Year's Accomplishments
Provisional data from the National Immunization Survey indicate that 78.2% of children ages 19-35 months have completed the recommended schedule of immunizations in Hawaii in 2008. The State objective was not met nor was the Healthy People 2010 national objective of 80%.
After 5 years of relative stability, the 2007 rates increased substantially with an equally steep decline in 2008. The reason for this variation is unknown and rates will be closely monitored in the future.

Ongoing direct services to increase child immunization rates include safety-net programs such as immunization clinics supported by Department of Health (DOH) Public Health Nursing (PHN) and the federally funded Vaccines for Children (VFC) Program at primary care health centers that serve children without health insurance or with Medicaid.

Ongoing enabling services include parent education, referral and follow-up for immunizations through purchase-of-service contracts administered by the Title V agency for primary care services for the uninsured, Healthy Start, and WIC. The Hawaii Covering Kids program continues outreach efforts to enroll uninsured children into the state Medicaid program (Med-QUEST).

Within the DOH, the Hawaii Immunization Program (HIP) is the lead agency for children's immunizations. It administers state and federally funded vaccine programs, provides information on immunization schedules, vaccination availability and immunization policies. The Title V agency works closely with HIP on population based and infrastructure development activities.

Results of HIP's retrospective study of immunization records for all kindergarteners entering school in 2002 was published in September 2007 on the Journal of Pediatrics online version. The results showed factors for delayed immunization included: 1) delayed immunization at 3 months of age, 2) living in Maui County, 3) living in a neighborhood where a low proportion of adults had postsecondary education and 4) living in a neighborhood where a high proportion of households spoke a language other than English at home. The majority (80%) of under-immunized children would have required only 1 additional visit to bring them up-to-date.

Statewide, population-based services focused on increasing public awareness and included the outreach efforts of the Hawaii Immunization Coalition's (HIC) Infant Immunization Sub-Committee. HIC is a statewide, community-based coalition of public and 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, through

education and outreach to the general public and service providers.

HIP continues to mail out "Protect Your Keiki Now" immunization reminders monthly to parents of children at birth and at ages 4 months and 12 months, and to distribute brochures on school entry requirements and general immunization information. Copies of the multi-language read-to-me immunization coloring book continue to be distributed to programs statewide.

HIP assisted WIC staff with examining their immunization screening and documentation practices and developed a plan to improve reliability of immunization data collected at clinics. Based on the results of the review, a plan was outlined to provide an in-service training to WIC clinic staff on the documentation process and to make changes in WIC policies and procedures to improve immunization assessment activities.

HIP convened a coalition of stakeholders, including health plans, community health centers and private physicians to assist with the development of an immunization registry. In December 2007, HIP procured a statewide web-based immunization information system through Electronic Data Systems Corporation that facilitates tracking and identification of children who are out of compliance. The Hawaii Immunization Registry (HIR) was established in February, 2008, and began pilot testing in September 2008.

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. Send out immunization reminder notices to parents of children born in Hawai'i under 1 year old.			X	
5. Provide education and outreach to promote immunization awareness.			X	
6. Support collaboration among agencies/programs to improve child immunization rates.				X
7. Develop policy to support increased immunizations among children.				X
8. Monitor immunization rates.				X
9. Conduct research to identify barriers to higher immunization coverage levels.				X
10. Develop a statewide immunization registry.				X

b. Current Activities

Title V staff participate in HIC activities to plan outreach and education for healthcare providers, community agencies and Title V programs.

Initial pilot testing of the HIR ended in March 2009 at seven Oahu sites: 4 private pediatricians' offices, a Public Health Nursing office, Waimanalo Community Health Center and the Hawaii Homeless Outreach & Medical Education (HOME) project (The HOME project provides free medical care to the homeless using university medical school students, residents and physicians). Providers at the seven sites entered over 24,000 immunization records into the HIR.

Statewide implementation will begin August 2009 on a voluntary basis. HIR staff conducted

demonstrations of the registry at the HIC Congress meeting, Kokua Kalihi Valley community Health Center, American Academy of Pediatrics (AAP) -- Hawaii Chapter meeting and the Hawaii Association of Family Physicians Conference. In addition, HIR provider recruitment brochures were distributed to VFC providers statewide. The HIR will have the capacity for immunization data transfers from Community Health Centers' electronic medical records systems.

The Hawaii Chapter of the AAP, EPSDT coordinators of various MedQUEST Plans and the MedQUEST EPSDT nurse collaborated to strategize methods to promote immunization compliance.

c. Plan for the Coming Year

Provisional data for 2008 will be updated. The State objectives have been modified to meet 90% by 2010 since Hawaii has been close to meeting the HP 2010 objective of 80%.

Title V will continue to support services described in the previous years.

The Hawaii Covering Kids Program efforts will continue to provide enabling services targeting disparate families including immigrants, Native Hawaiians, Pacific Islanders and the families of displaced workers. Title V will continue to support Covering Kids through participation in the Advisory Task Force as well as its subcommittees.

All Title V programs, including primary care purchase-of-service contracts and WIC, will continue to provide education, referral and follow-up for infant/child immunizations. Program data on immunization coverage will be reviewed and monitored from these contracts and programs. Technical assistance will continue to be provided to early childhood programs within the Title V Maternal and Child Health Branch (MCHB) to improve immunization rates.

HIP and the HIR coalition will continue to oversee the development of the statewide HIR. This effort is helping Hawaii meet the HP 2010 objective to increase the proportion of children who participate in fully operational population-based immunization registries. The Coalition is also working with private agencies, such as the health insurance providers, toward electronic transfer of immunization information across the life span. Plans are in progress to introduce legislation next year to officially establish HIR in statute as well as eliminate the need for specific patient authorization for inclusion in HIR. In an effort to increase participation, the DOH plans to include the HIR consent option on the 2009-2010 school-based influenza vaccination program, Stop Flu at School, consent form.

HIP will assist WIC to evaluate its efforts to improve immunization rates among its clients including staff training, procedure changes, and the accuracy of documentation.

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	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	23	22.5	22	18.6	18
Annual Indicator	18.5	19.4	21.6	19.8	18.7
Numerator	440	466	519	472	432
Denominator	23802	24061	24065	23857	23097
Data Source					Data Source

					(numerator): Hawai'i State. Department
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
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	17.5	17	16.5	16	15.5

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated birth data file. Data for the year 2007 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, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

Notes - 2006
Data is for resident population and is by calendar year. Data for the year 2005 was revised with an updated birth data file. Data for the year 2006 is based on a provisional birth data file Population data based on U.S. Census Bureau, Population Estimates Program, SC-EST2006-AGESEX_RES: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2006. Release Date: May 17, 2007.

a. Last Year's Accomplishments
The 2008 provisional data indicate a rate of 18.7 live births per 1,000 teenagers aged 15-17, a slight decrease from 2007. The State objective of 18 per 1,000 was nearly met. The comparable Healthy People 2010 objective for this Title V measure is to reduce pregnancies among females aged 15-17 years to no more than 46 per 1,000 females aged 15-17. Hawaii continues to meet the objective. In 2007, there were 34.5 pregnancies per 1,000 females aged 15-17 years.

The 2007 Hawaii Youth Risk Behavior Survey (YRBS) results showed 36.2% of high school students reported having sex at least once; and 23.6% reported being currently sexually active. The rates are similar to those in 2005 and remain lower than U.S. average.

The Department of Health (DOH) and the Department of Human Services (DHS) have a Memorandum of Agreement (MOA) to support teen pregnancy prevention activities using Temporary Aid to Needy Families (TANF) funding. TANF funds support a position within the Title V Adolescent Wellness Program to coordinate the State's teen pregnancy prevention (TPP) efforts and to provide technical assistance (TA) and oversight for TANF funded programs conducted during non-school hours.

Title V staff assisted with training and TA for TANF teen pregnancy providers to improve evaluation methods using standardized performance measures for TPP and positive youth developed programs. The measures were developed by the national consulting firm, the Lewin Group. The providers now use the methods to report program outcomes.

Title V continues to receive federal Abstinence Only Education (AOE) grant funding and contracts the Boys and Girls Club of Hawaii (BGCH) to provide services. BGCH utilizes a "Start Smart" curriculum that encourages healthy youth development. Due to the late receipt of federal funding in 2008, provision of services was confined to only a few communities with relatively high teen births.

The Hawaii Catholic Charities (CC) is the sole state Community Based Abstinence Education grant recipient. CC continues to use the "Try Wait!" abstinence-only (AO) curriculum in the public schools. Although this curriculum is not in compliance with the Board of Education's abstinence-based education policy, individual school teachers continue to request it in classrooms. CC also provides AOE in private and charter schools as requested. With a TANF grant from DHS, CC also provides case management and the abstinence-only curriculum to the National Guard Youth Challenge graduates.

The Hawaii Youth Services Network (HYSN) continues to provide technical assistance and training to schools, community based organizations and health educators serving youth to use science-based approaches to prevent teen pregnancy. HYSN was 1 of 9 state organizations chosen to participate in the Centers for Disease Control and Prevention (CDC) Promoting Science-Based Approaches (PSBA) grant in 2005 which supports this work.

In 2008, HYSN formed a statewide TPP leadership team, called the Healthy Youth Hawaii (HYH), to provide guidance for continued capacity building activities. HYH also assisted with the May 2008 Teen Pregnancy Prevention Month activities and sponsored a slogan/art contest that was used in public informational materials.

In 2008 the Legislature made a supplemental appropriation of $1.7 million to provide Family Planning Program (FPP) statewide contracted services including community based health education outreach services for teen pregnancy prevention.

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 prevention programs funded with Temporary Assistance to Needy Families funds.				X
5. Assure Temporary Assistance to Needy Families funds for teen pregnancy prevention are utilized effectively.				X
6. Contract for Abstinence Only Education Program to selected at-risk communities.		X	X	X
7. Contract for family planning educational outreach and clinical services.	X	X	X	X
8. Support the administration of the Youth Behavioral Risk Survey in High Schools and Middle Schools to collect student health data for program planning.				X
9. Provide training to adolescent service providers to encourage use of evidence based practices to improve the effectiveness of service delivery.				X
10.				

b. Current Activities

Title X FPP health educators provide expanded outreach services to teens on the benefits of abstinence, delaying sexual intercourse, contraception options, and importance of consistent

condom use.

Title V staff work in collaboration with Title X FPP to reduce teen pregnancy and unintentional pregnancy rates through increased public awareness.

The first Teen Pregnancy Awareness Summit was held in October for Hawaii's legislators and other government officials to serve as a reminder of the need for teen pregnancy prevention (TPP) resources. The Summit was followed by a DOH, DOE, and HYSN TPP training for providers and teachers. Presentations included the latest TPP statistics; a review of the Hawaii standards for health curriculum and instruction, and how to use evidence-based TPP programs to meet these standards.

The 2009 Legislature passed SB 777 which mandates all state-funded sex education programs provide medically accurate, factual, comprehensive, and age-appropriate information. DOH supports this measure through FPP, pregnancy counseling, sexually transmitted disease (STD)/HIV and sexual health education programs; however the federal AOE program does not comply with this mandate.

Hawaii received the five year (FY 2009 to 2013) Title V abstinence-only education (AOE) federal grant. Later, the AOE grant legislation was not reauthorized and expired on June 30, 2009. Thus, the Boys and Girls Club of Hawaiì that provides contracted AOE services ended.

c. Plan for the Coming Year

The 2008 provisional data will be updated in next year's report. Objectives have been set to decrease by 2% annually.

In 2009, Title V convened an adolescent advisory work group of state and private agency managers to work with the Adolescent Wellness Program to develop a system wide well-being plan for Hawaii's adolescents. The plan will eventually serve as a resource guide to promote ways to provide and support youth development opportunities, learning experiences and provide the support needed to assure youth connectedness and readiness for adulthood. The workgroup continues to meet.

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

Should federal grants for comprehensive sex education become available the State TPP specialist will apply if appropriate and/or share information on funding opportunities to providers in the health community.

Title V has secured epidemiological services to analyze the Youth Risk Behavioral Survey data for dissemination to school officials and staff, parents and the general public. Fact sheets on sexual behavior indicators will be included. For more information see the narrative for HSCI 9B.

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	2004	2005	2006	2007	2008

Annual Performance Objective	26	25	25	26	26
Annual Indicator	24.1	24.7	25.6	27.7	22.5
Numerator	725	782	886	824	554
Denominator	3009	3171	3460	2971	2457
Data Source					Data Source (numerator, denominator): Hawai'i Stat
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
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	27	27	28	28	28

Notes - 2007
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. Objectives were revised based on FY 2004 indicator.

Notes - 2006
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.

Objectives were revised based on the FY 2004 data.

a. Last Year's Accomplishments
The data for this measure comes from the Department of Health's (DOH) Dental Health Division (DHD). For the 2008-2009 school year, the indicator was 22.5. The State objective was not met nor was the Healthy People 2010 goal of 50%. The 2006 data shows the first decline in dental sealants in 6 years. The reasons for the decline are unknown at this time.

Hawaii's children continue to have worst rates oral health in the nation despite relatively high dental insurance coverage. Private and public stakeholders continue to work together to improve the oral health of children in Hawaii.

In 2003 the Hawaiian Islands Oral Health Task Force (HIOHTF) completed an integrated plan to improve oral health in Hawaii. Its statewide membership of public and private groups continues to develop steps toward plan implementation. The Tri-County Oral Health Task Force comprised of the neighbor island dental coalitions meets quarterly while the Kauai Dental Health Task Force, the Hawaii Island Dental Task Force, and the Maui Oral Health Task Force continue to meet separately to address the needs of their communities. The groups ensure their efforts mirror the content areas and objectives found in the Task Force's plan. The neighbor islands groups continue to be strong advocates for improving children's oral health.

Statewide, DHD remains the lead agency in children's oral health data. DHD conducts the child oral health surveillance program, which compiles statewide data on children's oral health in accordance with accepted dental epidemiology standards. DHD's dental hygienists continue to

conduct oral screenings and education in various public elementary schools, administer fluoride rinse programs to participating Department of Education (DOE) schools and follow-up in cases where serious oral health problems are identified. DHD also provides information resources, training and technical assistance to numerous MCH programs including WIC.

WIC programs educate their clientele on early childhood caries prevention and the importance of the dental home and regular care.

Medicaid-QUEST provides fee-for-service dental care to encourage more dentists to see children with Medicaid coverage. Community Case Management Corporation is contracted to provide a case management component for children who have difficulty accessing dental services. Medicaid-QUEST provides dental care for pregnant women which also indirectly prevents caries formation in their children.

Community-based safety net providers, through State-funded primary care contracts, provide dental services on-site for the underinsured and uninsured populations to ensure comprehensive care.

The 2007 Legislature passed Act 199 to perform an assessment of the dental care services in the State. The University of Illinois at Chicago Dental School was contracted by the DOH DHD. The 2008 assessment report was finalized and released in June, 2009 with recommendations to improve the system of services for dental care in the State. Due to the significant economic downturn, there are limitations in the capacity of the public health and public assistance systems to address these recommendations at this time.

In 2008, the regional Health Resources and Services Administration (HRSA) office convened a Hawaii State Strategic Partnership Session which developed action steps to improve oral health care and prevention education. The Hawaii partners included federal HRSA grantees and key stakeholders including DOH programs, Hawaii Primary Care Association, Papa Ola Lokahi (the Native Hawaiian health system), Med-QUEST and the Hawaii Dental Association. The leadership has reconvened a meeting in July, 2009 to address the work plan developed in 2008 and to consider changes due to the severe budget restrictions.

The Maui Community College's accredited Dental Assistant training program continues to offer low cost dental services to the community at its training site.

On Maui, a Hui No Ke Ola Pono (Native Hawaiian Health System) dentist provides preventive education and assessment at various elementary schools on the island.

The Department of Human Services Head Start Collaborative shared the "Cavity Free Kids" curriculum from Washington State which has been used by Title V staff statewide.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide oral screenings, education and provide follow-up for serious cases in elementary schools.	X	X	X	X
2. Administer fluoride rinse programs in public schools.	X			
3. Collect, analyze and publish oral health data on children.				X
4. Provide funding for dental services to the under- and uninsured through community health centers.		X		
5. Provide oral health education to WIC low income pregnant women and young mothers.		X		

6. Implement provisions of the Oral Health Action Plan.				X
7. Support Neighbor Island oral health community coalitions to plan and conduct activities/programs.				X
8. Convene key stakeholders to identify and implement specific strategies to improve oral health for children.				X
9.				
10.				

b. Current Activities
On Molokai, a Federally Qualified Health Center has been established and has a full time dentist and dental hygienist addressing the critical need for dental care for this rural community. The Waimanalo community health center serving rural Windward Oahu opened a new dental clinic in April 2008.

The communities on the North/West areas of the island of Hawaii are served by mobile dental units and have a new pedodontist in a new clinic in Kona.

DHD developed a dental health curriculum which is taught in public school health classes. The curriculum meets the DOE standards established for health education to promote child and adolescent wellness in Hawaii.

The State Strategic Partnership will reconvene to review the work plan developed in 2008.

Hawaii was one of 12 states to join the next phase of the national Head Start Dental Home Initiative developed in partnership with the American Academy of Pediatric Dentistry (AAPD). The project goal is to assure all children enrolled in Head Start and Early Head Start (roughly 3,000 low-income children in Hawaii) have access to oral health care through a network of pedodontists and trained general dentists. The Hawaii Dental Association is identifying dentists statewide to participate in the program and help train those dentists who usually do not see young children. The Hawaii Head Start launched the project in May 2009 in conjunction with the annual meeting of the AAPD held in Honolulu.

c. Plan for the Coming Year
The objectives for this measure are set to increase 1 percentage point every 2 years. The decline in the dental sealant rate and other oral health indicators will be closely monitored.

DHD will continue to work with public and private community partners to promote the "Dental Home." DHD will continue screenings, fluoride rinse and education programs in schools. Title V will continue to support the DHD to acquire current statewide data for this measure and other child oral health indicators using federal State System Development Initiative (SSDI) grant funding.

WIC programs will continue to provide oral health education for their clients.

Title V will support the recommendations of the HIOHTF and assist in moving it forward. In addition, efforts will continue to support the safety-net providers to expand their dental capabilities to provide direct services to the underinsured and uninsured, especially designated low-income Health Professional Shortage Areas on Hawaii, Maui, Kauai and Molokai.

Title V also recognizes the serious oral health care challenge for Hawaii's children. Plans are to build on existing infrastructure services by focusing on the utilization of the existing oral health resources, with emphasis on the dental home. Title V staff will continue to collaborate with DHD, the dental providers, pediatricians, and community programs serving families to ensure that each child has an appropriate dental home and is accessing routine care, particularly, children with

special needs. The proper use, placement and monitoring of dental sealants is one important aspect of this preventive, routine dental care. Most dental insurance plans in Hawaii cover sealant placement and the number of children with insurance is relatively high, although this may decline with the state's economic downturn and increased layoffs.

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	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	2	3	2	1.4	2
Annual Indicator	1.9	2.0	2.7	2.5	2.5
Numerator	14	14	19	18	18
Denominator	745237	706304	715232	712175	712175
Data Source					Data Source (numerator): Hawai‘i State. Department
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.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2	2	2	2	2

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated death data file. Data for the year 2007 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, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008). 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.

Notes - 2006
Data is for resident population and is by calendar year. Data for the year 2005 was revised with an updated death data file. Data for the year 2006 is provisional. Population data based on U.S. Census Bureau, Population Estimates Program, SC-EST2006-AGESEX_RES: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2006. Release Date: May 17, 2007. 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.

a. Last Year's Accomplishments
Three-year averages were used to calculate the indicator for this measure because the numbers are small and vary substantially from year to year. The provisional data for the 2007-08 indicator is 2.5. The State objective was nearly met. The rates have stayed relatively stable over the past 5 years.

The numbers for this measure are small and may vary substantially given 1 or 2 motor vehicle crashes. The actual number of crash-related deaths (occupant, pedestrian, bicyclist and non-traffic) in 2007 was 9 and 2 for 2008.

Title V partners with the Keiki Injury Prevention Coalition (KIPC), DOH Injury Prevention and Control Program (IPCP) and the State Department of Transportation (DOT) Safe Communities Initiative to provide information on modifiable risk factors and education through an extensive network of community agencies.

DOH's Child Death Review (CDR) invites prevention programs to its meetings to learn more about available community resources. Examples include: Queen's Medical Center's (QMC) car seat educational program which expanded to expectant parent classes; Kauai Police Department's "Roadblock" program; Honolulu Police Department (HPD) projects KISS (Kids in Safe Seats), GET SAFE (Give every teenage student alcohol free education), and Smart JPO.

The Honolulu Medical Examiners' Office promotes prevention through morgue tours and school visits. Presentations cover risk factors related to motor vehicle crashes such as drinking alcohol, using drugs, speeding, and lack of safety restraints.

Hawaii has been progressive in passing child passenger safety legislation. Laws are in place requiring safety seats for those up to 4 years of age; children ages 4-8 years and under 80 lbs must also be in a safety or booster seat. Other laws require attendance at a special class for parents ticketed for not having their child in a safety seat and prohibiting children under 12 from riding in a truck bed.

The 2007 DOT Child Passenger Safety (CPS) study reported children aged 2 and above are in car seats at substantially lower levels than infants. The lowest compliance rate was among booster seat users and inappropriate use of restraints.

KIPC received a Safe Kids grant to educate law enforcement regarding the recently passed booster seat law. In 2008 a 10 minute in-service on the law was offered to HPD personnel to support the "Click it or Ticket" car restraint enforcement campaign.

CPS activities help parents/caregivers to properly install car seats. The CPS training curriculum was recently revised. Statewide, 58 technicians were certified in 2008 through trainings held in most of the counties. KIPC and Kapiolani Medical Center for Women and Children (KMCWC) provide education on the safe transport for children with special needs. KIPC's CPS program coordinator attended the national Life Savers Conference for updates on motor vehicle prevention resources.

The DOT reported 51 community car seat checkups and 21 fitting service stations statewide. A total of 1,082 car seats were evaluated statewide.

The DOH Injury Prevention and Control Program developed a media campaign "No Get Hurt Hawaii." Pedestrian and bike safety PSAs were included and shown on closed circuit TV at the QMC.

The DOH Healthy Hawaii Initiative offered 2 Walkable Community workshops to train neighborhood leaders how to assess roadway conditions to make their communities safer for

walking. Two high schools on Oahu hosted "Shattered Dreams," which documents the deadly consequences of hazardous driving.

The Hawaii bicycle helmet law requires helmet use for children ages15 years and younger. ThinkFirst, through a bike safety grant from the American Legion, did presentations for elementary school students and their parents on bike helmets. A new brochure on bicycle safety was distributed.

The Hawaii Bicycling League conducts bike safety classes for thousands of 4th graders on Oahu in the schools. The program is funded by bicycle registration fees collected by the City.

Implementation of DOT's Strategic Highway Safety Plan: 2007-2012 continues to address population-based prevention of motor vehicle deaths. Activities include the passage of an Ignition Interlock bill in 2008 to keep drunk drivers off the roads. The bill establishes a task force to make recommendations on implementation for the program to the 2009 Legislature.

Also passed in 2008, a bill to allow traffic citations to be issued to parents/caregivers if children under age 9 are left unattended in vehicles.

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 and pedestrian safety.			X	X
3. Enforce seat belt and child safety laws through “Click It or Ticket” 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. Conduct training for safety seat inspection/installation technicians and instructors.			X	X
6. Conduct safety seat inspection and loaner program for children with special needs.		X		
7. Identify prevention strategies by reviewing information surrounding child deaths.				X
8. Support state and community injury prevention coalitions.				X
9. Advocate for policy/legislation to improve child safety in motor vehicles.				X
10.				

b. Current Activities

DOT is funding a survey to evaluate the booster seat law and the "Click It or Ticket" car restraint enforcement campaign. DOT is also developing a new workgroup to develop a new media campaign and brochure about the CPS laws for children under age 8 years.

Title V continues to support IPCP and DOT in promoting compliance with child restraint, safety belt, and helmet laws.

The DOH Injury Prevention Advisory Committee and GEICO co-sponsored a Traffic Safety category for the Olelo Youth Xchange Video Competition and 9 finalists were aired statewide in April 2009.

During Helmet Safety month, QMC Trauma Services and Emergency Department sponsored a helmet giveaway for children under the age of 18 years. Media coverage for the program was secured to increase awareness about the safety issue and helmet law.

In May 2009, representatives from Title V agency, CDR and IPCP attended the "Keeping Kids Alive: National Symposium" to strengthen integration of strategies for prevention policies and efforts.

In 2009 the Legislature amended the 2008 Ignition Interlock law with specific implementation details and set the program start date for 20011. Also passed was a Complete Streets bill requiring DOT and county transportation departments to reasonably accommodate access and mobility for all users of public highways.

The City of Honolulu began enforcing a new law prohibiting the use of mobile electronic devices while operating a motor vehicle, primarily cell phones, in July 2009.

c. Plan for the Coming Year

Implementation of DOT's Strategic Highway Safety Plan: 2007-2012 will continue to address population-based prevention of motor vehicle deaths.

Child Death Review teams will be informed about DOT plans to improve roadway safety by design, safeguard pedestrian and bicyclists, and ensure motorcycle and moped safety as well as occupant protection.

The DOT will support CPS instructor training during October 2009 in order to increase the number of certified instructors statewide. Support for 21 fitting stations in all counties including re-establishment of a fitting station for Kauai and the islands of Molokai and Lanai will continue. Additional fitting stations and community car seat checks will be added as funding sources are secured. DOT will continue to fund the occupant safety survey in all counties.

Addressing infrastructure to prevent child injuries, the Hawaii Injury Prevention Plan (2005-2010) will be revised in the upcoming year. Google mapping of EMS responses for all levels of injury will be used to expand the HEMIS (Hawaii Emergency Medical Systems Injury Surveillance) system.

IPCP will support efforts to pass new legislation requiring large school buses to have an operable seat belt assembly at all designated seating positions in order to pass inspection. Other legislation includes expansion of the Graduated Licensing Law to prohibit youth from engaging in various tasks that distract from driving.

Title V programs serving young families (i.e. Keiki O'Hawaii Guide, Healthy Start, and Women Infant and Children clinics) will be used by DOT to distribute the new DOT CPS brochure on laws to protect young children and inform parents of common misuse of child restraint systems.

The HPD Traffic Division will conduct a minimum of two large weekend inspections to check for violations related to seat belt usage, drunk driving, and child passenger safety. These operations held at roadblocks also offer installation services.

A revised KIPC safety checklist based on developmental stages "Protect Our Keiki: at Home, at Play and on the Way" includes safety tips for the car, street, pedestrian and bike, and road. Copies will be distributed through Title V contracted service providers.

The Hawaii Bicycling League will continue conducting bike safety classes for 4th graders on Oahu schools. Similar programs are starting on the neighbor islands.

Planning efforts among the Children's Safety Network and Title V and IPCP are underway to develop cross-program integration of injury and maternal and child health.

The CDR system will work with Title V MCH Branch and IPCP to improve the prioritization and implementation of prevention recommendations based on multiple data and surveillance sources. This effort will include collaboration with DOT and other stakeholders.

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	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			46	47	48
Annual Indicator		55.5	50.7	54.5	54.5
Numerator		178	112		
Denominator		321	221		
Data Source					Data Source (numerator/denominator): U.S. Departme
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
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	55	56	57	58	59

Notes - 2008
The data for this measure is from the National Immunization Survey (NIS) http://www.cdc.gov/breastfeeding/data/nis_data/data_2004.htm by the Centers for Disease Control (CDC). This year, the NIS changed how breastfeeding data was reported. In the past, the NIS presented breastfeeding information by year of respondent interview; however, now breastfeeding information is presented according to the year of the child's birth. This change is intended to make it easier to evaluate breastfeeding interventions and progress toward the Healthy People 2010 breastfeeding objectives.

Notes - 2007
The data for this measure is from the National Immunization Survey (NIS) http://www.cdc.gov/breastfeeding/data/nis_data/data_2004.htm by the Centers for Disease Control (CDC). This year, the NIS changed how breastfeeding data was reported. In the past, the NIS presented breastfeeding information by year of respondent interview; however, now

breastfeeding information is presented according to the year of the child's birth. This change is intended to make it easier to evaluate breastfeeding interventions and progress toward the Healthy People 2010 breastfeeding objectives. The latest data is from birth year 2004, but reflects data collected during 2004-2005. This data is used to report for FY 2006 and 2007. The FY 2005 indicator reflects NIS data utilizing the old NIS reporting method, so is not comparable to FY 2006 data. The data for birth year 2005 is expected to be released by August 2008.

Notes - 2006

The data for this measure is from the National Immunization Survey (NIS) http://www.cdc.gov/breastfeeding/data/nis_data/data_2004.htm by the Centers for Disease Control (CDC). This year, the NIS changed how breastfeeding data was reported. In the past, the NIS presented breastfeeding information by year of respondent interview; however, now breastfeeding information is presented according to the year of the child's birth. This change is intended to make it easier to evaluate breastfeeding interventions and progress toward the Healthy People 2010 breastfeeding objectives. The latest data is from birth year 2004, but reflects data collected during 2004-2005. This data is used to report for FY 2006 and 2007. The FY 2005 indicator reflects NIS data utilizing the old NIS reporting method, so is not comparable to FY 2006 data. The data for birth year 2005 is expected to be released by August 2008.

a. Last Year's Accomplishments

The FY 2008 data (based on NIS data for infants born in 2005) indicates 54.5% of Hawai‘i mothers reported breastfeeding their infants at 6 months, an increase from the previous year's data (50.7% for infants born in 2004). Hawaii has seen an overall increase from 1999 (49.3%) when the NIS first started collecting breastfeeding data. The 2008 indicator met the objective of at least 47% of women breastfeeding their infants at 6 months of age. Hawaii also surpassed the national rate of 41.5% and exceeded the Healthy People 2010 objective of 50%.

The Title V program promotes 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 promote breastfeeding include: Pulama I Na Keiki, a statewide program targeting Hawaiian families; the federal Healthy Start Project on the island of Hawaii; Early Head Start as well as programs under the Native Hawaiian Health Systems.

WIC provides comprehensive breastfeeding promotion, education and support to their pregnant and postpartum clients. Services include an incentive program, a breast pump loan program, a nationally-recognized Pumps in the School (PITS) Program in 18 high schools statewide, and breastfeeding peer counselors (BFPC). WIC maintains state and local agency level breastfeeding coordinators (BFC). The WIC State BFC hosts the Centers for Disease Control (CDC)/United States Breastfeeding Coalition (USBC) teleconference every other month for the State of Hawaii.

WIC contributes breastfeeding data to the national Pediatric Nutrition Surveillance System (PedNSS) report, which represents low income residents. The 2008 Hawaii rate of any breastfeeding at 6 months was 38.1% an increase over 2007 (35.8%) and was better than the national rate of 25.4%. Because WIC serves low-income, high-risk women the rates for breastfeeding are lower than for the general population.

Hospital delivery centers are also proponents of breastfeeding. Kaiser Permanente Hospital holds the prestigious designation of "Baby Friendly" hospital. Kapiolani Medical Center is currently working toward its designation. All of the delivering hospitals in the State have lactation consultants or utilize the services of nurse midwives to provide support to their breastfeeding moms.

The University of Hawaii Medical School Residency Program in the third year curriculum provides three and a half hour breastfeeding instruction for all pediatric residents and a two-hour session for all obstetric residents.

The Hawaii Breastfeeding Coalition (HBC) provides State leadership for breastfeeding promotion. The HBC has a website with information on services for breastfeeding mothers. They honor individuals and programs that support breastfeeding and continue to promote workplace lactation support by using "The Business Case for Breastfeeding" resource kit published by the U.S. Department of Health and Human Services. Hawaii was one of 10 states chosen to receive training on the toolkit at a national conference in Arlington, Virginia.

The HBC annual conference featured nationally renowned speaker and lactation consultant, Amy Spangler. A professor from the University of Hawaii described her breastfeeding research, a lactation consultant from Tripler Hospital discussed challenges facing military families, and the WIC BFC spoke on breastfeeding support at WIC.

WIC contracted with Parents And Children Together (PACT), one of Hawaii's leading private non-profit family service agencies, to provide technical support to the first BFPC placed at a community health center. The BFPC provides breastfeeding information to prenatal women and support to postpartum women via home and hospital visits. PACT completed the training of two BFPCs at Wahiawa WIC in rural Oahu. All WIC staff at the Waianae Coast Comprehensive Health Center, a community health center in another rural Oahu area, received training in the BFPC program. One staff member completed the entire training and is designated as a BFPC.

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	
3. Employ lactation consultants or nurse midwives at hospitals to provide breastfeeding support to new mothers.		X		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 major statewide breastfeeding promotional events and campaigns.				X
8. Pursue a position in Department of Health to promote breastfeeding across all departmental programs.				X
9. Conduct training and certification for breastfeeding counselors and lactation consultants.				X
10. Support, encourage and advise hospitals in moving towards “Baby Friendly Designation”.				X

b. Current Activities

The new WIC food package for infants to be implemented on October 1, 2009 includes baby food fruits and vegetables, baby food meats for exclusively nursing infants, decreases the amount of formula and eliminates juice. The State BFC developed and revised materials for WIC staff to educate participants about breastfeeding and the food package changes for infants requiring formula.

WIC continues to focus on breastfeeding promotion, education and support to their pregnant and postpartum clients with breastfeeding incentive items, breast pumps, and the school PITS

Program. A 6-hour training was provided by the State BFC to all WIC staff on communication skills, risks of formula use, the case for exclusive breastfeeding, and overcoming barriers.

WIC will provide materials for local agencies for the World Breastfeeding Event 2009 in August. This year's theme is: Breastfeeding: A Vital Emergency Response: Are you ready? The WIC State BFC continues to host the CDC/USBC teleconference calls every other month for the State.

PACT collaborated with Family Support Services of West Hawaii to provide BFPC training to their home visiting staff as well as staff from the Kona WIC Program.

WIC continues to provide information on the New Mothers Breastfeeding Act at all local agencies. The Act protects women's ability to breastfeed and express milk, encourages employers to establish policies to accommodate those activities, and protects the women's right to breastfeed in public places.

c. Plan for the Coming Year

Final data for births in 2005 will be provided in next year's report from the National Immunization Survey (NIS). Objectives for this performance measure were set to increase at 1% each year based data using the old NIS method for calculating breastfeeding rates. After examining the new NIS data for this measure, objectives will not be revised until a clear trend emerges. NIS data show rates have varied substantially from 34.1% in 2000 to a high of 55.4% in 2003, back down to 50.5% in 2004 and up again to 54.5% in 2005.

Hawaii has a history of strong breastfeeding initiation rates at more than 80%. The following activities will address the efforts to increase breastfeeding duration rates as well as exclusive breastfeeding.

Title V recognizes that there is a need for breastfeeding support in the work place to include a breastfeeding friendly environment with private rooms, commercial grade breast pumps, milk storage arrangements, adequate personnel breaks during the day, flexible work schedules, and on-site childcare facilities. WIC will continue to support the efforts of the HBC and legislation to assure employees are provided adequate pumping breaks and continue to assure that breastfeeding women are protected from discrimination. Hawaii WIC will continue to encourage the establishment of lactation rooms at each Department of Health (DOH) building or campus.

Title V will expand their efforts to encourage all hospitals to obtain the "Baby Friendly Designation" using the experience of the California Department of Public Health campaign to do the same in their state. A previous internal chart review of 100 WIC records from a local hospital indicated that over 50% of pregnant women who expressed the desire to breastfeed upon admission were using formula upon discharge. The Title V program staff will continue to provide comprehensive breastfeeding education and support to high-risk pregnant women.

WIC plans to support existing BFPCs, train additional BFPCs, expand BFPC services to include visiting clients in the maternity ward and at home after delivery, to continue to offer training for WIC and community partners, expand the PITS Program, breastfeeding incentive program, and the breast pump loan program. Details are available on the website at http://hawaii.gov/health/family-child-health/wic/. WIC activities around World Breastfeeding Week will increase awareness and support for the benefits of breastfeeding.

WIC will continue the implementation of the new food package for participants. The WIC State BFC will continue to support staff on the new food package for breastfeeding moms. Because the new package decreases the amount of formula for partially nursing mothers, WIC must ensure these women do not stop breastfeeding to receive more formula.

Unfortunately, the DOH budget will not support efforts to secure a breastfeeding professional position across all programs.

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	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	98	98	98	98	98
Annual Indicator	98.0	97.6	98.3	98.1	97.6
Numerator	17882	17417	18573	18725	18950
Denominator	18246	17839	18888	19085	19407
Data Source					Data Source (numerator): Hawai'i State. Department
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
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98.4	98.4	98.4	98.4	98.4

Notes - 2007
For 2002-2004, the denominator is from vital records of live births minus deaths before 24 hours. Beginning in 2005, 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 EHDI program for use in annual calendar year (CY) reports to the Centers for Disease Control and Prevention. Data for CY 2006 (Jan-Dec) were updated. Data for CY 2007 (Jan-Dec) are preliminary.

Notes - 2006
The denominator for this measure is from birth records reported minus infant deaths within one day. The numerator is the number of these infants who were screened before discharge, as reported on annual Early Hearing Detection and Intervention (EHDI) reports to the Centers for Disease Control and Prevention. Data is reported by calendar year. Data for FY 2005 was updated. Data for FY 2006 is provisional.

a. Last Year's Accomplishments
The 2008 indicator was 97.6%, which was close to meeting the objective of 98%. The CY 2008 data are preliminary and will be updated next year.

The 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.

Amendment of the law in 2001 mandated screening all newborns for hearing loss and reporting of

screening results to the DOH. In January 2002, Imua Family Services piloted screening of Maui homebirth children. In 2003, NHSP began outreach to homebirth families statewide through midwives. Hearing screening is now available to families statewide, regardless of birth location. As of November 2006, all hospitals have both otoacoustic emissions and auditory brainstem response screening capability and have backup equipment. Three hospitals had replacement of obsolete backup equipment.

In 2008, the number of hospitals delivering and screening babies remains at twelve. Eleven of the twelve hospitals transfer child-specific data to the state NHSP HI*TRACK data system. The remaining hospital submits annual aggregate data to NHSP; however, this information is not adequate for state follow-up purposes. Discussion continues with the hospital regarding child-specific data submission.

NHSP continued to work closely with hospitals and medical home providers in 2008. NHSP worked with hospitals monthly to reconcile state data against hospital delivery logs and track follow-up needs.

Protocol was updated to include calls to doctors for assistance when infants were referred to NHSP for follow-up. If an infant missed or failed inpatient or outpatient screening and a referral was made to NHSP by the hospital screener, NHSP staff contacted both the parents and infant's primary care physician (PCP) to follow-up. All screening or evaluation reports were sent to infant's PCP.

A Hawaii Practitioner's Manual for Early Hearing Detection and Intervention (EHDI) was developed and distributed to pediatricians and medical home providers. The manual explained the protocols for newborn hearing screening and the roles of medical home providers in detecting possible hearing loss. When the practitioners understood the protocols and the importance of hearing screening, they were more willing to discuss the issues with the parents. Since the distribution of the Practitioner's Manual, NHSP has had greater success in contacting the families through the practitioners' office as a second point of contact. These families would otherwise be lost to follow-up due to missing or wrong contact information in the NHSP database.

NHSP collaborated with the Early Intervention Section (EIS) in developing a method to identify children receiving early intervention (EI) services. At the time of enrollment in an EI program, parents are asked to sign a consent form to share information with NHSP. The EIS database of children whose families signed the consent can be electronically matched to the NHSP database to identify children receiving EI services who had been lost to follow-up/documentation for newborn hearing screening or evaluation. The data sharing and consent form would allow NHSP to identify and contact the EI care coordinator s to ensure that children received appropriate diagnostic audiological evaluation and needed follow up services.

NHSP, with the support of the Children with Special Health Needs Branch (CSHNB) Research Statistician, continues to monitor the percentage of children who are lost to follow-up/documentation at all stages and to document progress.

Administrative rules for NHSP were drafted and are now in the lengthy process of being approved.

Funding from the MCH Bureau for the Baby Hearing Evaluation and Access to Resources and Services (Baby HEARS)-Hawaii project supported the CSHNB/NHSP efforts to improve newborn hearing screening and follow-up in Hawaii during 2008.

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. Home birth 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, audiologists, and other providers about EHDI.				X
9. Promulgate 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.

Newborn Hearing and Metabolic Screening Programs coordinate quality assurance efforts and provide brochures/letters to home birth families through Birth Registrars and periodic mailings to physicians, midwives and naturopaths.

The hospital newborn hearing screening coordinators subcommittee met in April 2009, where the 2007 Hawaii and national screening data were presented, success stories were shared and suggestions for program improvement were discussed. The EHDI Advisory Committee will meet in July 2009 to discuss improving the system for identification and intervention of infants with hearing loss.

NHSP participates in the National Initiative for Children's Healthcare Quality's (NICHQ) Learning Collaborative B, "Improving the System of Care for Children and Youth with Special Healthcare Needs: The NHSP team". This one-year project focuses on reducing the loss to follow-up in screening, evaluation and intervention through learning collaborative activities implemented at pilot sites.

To help reduce the loss to follow-up, NHSP established protocols with H-KISS, the information/referral unit within EIS, to track the status of referrals made by NHSP. The Parent Coordinator also provides support to families as appropriate.

c. Plan for the Coming Year
Newborn screening will continue in all birthing facilities. NHSP will 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.

Data collection and tracking procedures will be improved. A higher version of HI*TRACK database system will be used. It will enable better tracking of missed screening or lost to follow-

up. 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, other public health programs 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 EHDI process. NHSP and the Newborn Metabolic Screening Program will continue joint quality assurance activities. NHSP will continue contacting hospitals monthly to reconcile state data against hospital delivery logs. Outreach to home birth families will continue.

Educational sessions/training will continue to be provided for hospital newborn hearing screening staff, audiologists, physicians, early intervention, and other providers. Strategies will be implemented to help reduce loss to follow-up/documentation at the evaluation and intervention stages of the EHDI process.

NHSP will continue to disseminate public awareness materials to inform parents, early intervention providers, and health professionals about early hearing detection and intervention. Hospital screener training materials will be disseminated.

NHSP will 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. Support to hospitals in the screening, tracking and data input system will be strengthened. The part-time 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 subcommittees will continue to meet and provide input on state program policies and procedures.

NHSP will continue to participate in the NICHQ Learning Collaborative. Activities planned include: develop care plan (roadmap) and other educational materials for families with infants who fail screening or evaluation, confirm contact information including a second point of contact, improve communication with infants' medical home, and provide parents support to Audiology Department of the pilot hospital. These activities will be implemented statewide if testing is successful at the pilot sites.

The process to establish administrative rules will continue.

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	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	2.7	2.3	1.8	1.8	1.4
Annual Indicator	3.7	2.1	2.2	3.9	3.9
Numerator	10802	6343	6343	11545	11545
Denominator	295174	295999	292999	293374	293374
Data Source					Data Source (numerator, denominator): Hawai‘i Stat

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
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3.7	3.7	3.7	3.7	3.7

Notes - 2008
Hawai‘i State Department of Health population estimate. The data is by calendar year and comes from a state-wide random sample survey and is subject to sampling variability. Data from the 2006 and 2008 surveys are not yet available.

Notes - 2007
Hawai‘i State Department of Health population estimate. The data is by calendar year and comes from a state-wide random sample survey and is subject to sampling variability. Data from the 2006 and 2007 surveys are not yet available.

Notes - 2006
Data comes from a state-wide random sample survey and is subject to sampling variability. An annual pace has been blueprinted to achieve zero disparities or this measure by the year 2010. The 2006 survey data is not yet available.

a. Last Year's Accomplishments
Data for 2006-2008 numerators are not available for this measure due to weighting issues of the survey results. The data will be updated next year.

The thrust of the Title V agency's efforts to decrease the percentage of children without health insurance is infrastructure building services, conducted in partnership with other State and community agencies.

The Title V agency continues to use the Hawaii Health Survey (HHS) data, an annual population-based residential telephone survey, because it currently provides the best consistent estimate of uninsured children. The same module of questions related to health insurance has been asked in the HHS since 1998 providing a degree of consistency and comparability. However, the limitations of a telephone survey remain: uninsured individuals are less likely to have a home telephone, and the trend toward more cell phone use along with the cancellation of residential phone lines.

Hawaii Covering Kids is a statewide initiative that identifies, enrolls and retains eligible children and youths in health insurance programs. HCK collaborates with Federal, State and community agencies to conduct outreach activities and works with State Department of Human Services (DHS), the state Medicaid agency, to improve policies and procedures to increase enrollment of children into the state Medicaid program (Med-QUEST). The Hawaii Primary Care Association began the project in 1999 with Robert Wood Johnson Foundation start-up funding. HCK is currently funded by local health insurers, State Department of Human Services (the state Medicaid agency), and through private grants and donations.

Over the past 10 years HCK has been extremely successful in leading and initiating efforts to increase children's enrollment into Medicaid and other private insurance sources through the work of its many committees including process simplification, media/public information, outreach,

training, and evaluation. HCK also maintains a user-friendly website that contains updated eligibility information and application forms for Med-QUEST children's coverage as well as private insurance plans for low-income children.

The new Centers for Medicare and Medicaid Services (CMS) Payment Error Rate Measurement (PERM) and Children's Health Insurance Program (CHIP) reauthorization policies prompted HCK to convene its Process Simplification Task Force to avoid any potential enrollment or processing barriers created by the federal policies. The Task Force met in 2007 and 2008 to outline Hawaii's Med-QUEST procedures to comply with the PERM program requirements to review selected claims for eligibility, medical necessity and claims data processing. The Task Force also developed plans to eliminate application and renewal error rates and minimize the eligibility documentation requirment to assure eligible enrollees easily qualify for Medicaid and CHIP programs.

As the cost of private medical insurance had increased, Hawaii responded by revising income eligibility levels to be able to cover more families. Hawaii expanded CHIP to provide free health insurance to children up to 19 years of age with family incomes up to 300% of the Federal Poverty Level (FLP). (Prior to April 1, 2008, families making up to 250% FPL received free health insurance for their children and families making between 251-300% FPL paid reduced monthly premiums.)

Hawaii uses State-only funds to provide free medical insurance for lawful permanent resident children and youths (possessing a "green card") living in the U.S. less than five years, refugees, and those born in the Marshall Islands, Federated States of Micronesia and Palau. As of December 30, 2008, there were 20,805 enrolled in CHIP and 3,622 enrolled in the Immigrant Children's program. Beginning April 2009, under the CHIP Reauthorization law, there was new funding for approximately 3,700 children, thus, saving the State $2.7 million annually.

HCK continues to inform parents and guardians about free health insurance through public and private schools, WIC, Head Start, organizations helping grandparents raising grandchildren, community groups participating in local fairs, legal aid offices, unemployment offices, youth clubs, and child care centers.

All Title V purchase-of-service contracts continue to require appropriate referrals for uninsured children who are eligible for health insurance coverage.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop improved methodology for measuring uninsured children.				X
2. Develop and implement new strategies for outreach to enroll uninsured children.				X
3. Develop and implement, in collaboration with the state Medicaid agency, new strategies to simplify the application and enrollment for the program.				X
4. Require Title V contractors to refer eligible uninsured children for insurance coverage.				X
5. Provide updated and timely user-friendly information and application materials to families regarding Medicaid program changes.			X	X
6. Ensure collaboration between the state Medicaid agency, state health insurance plans, policymakers, and community				X

service agencies to assure coverage for uninsured children.				
7. Advocate for legislation to support expanding health insurance coverage for gap group children.				X
8. 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
9.				
10.				

b. Current Activities

In April 2008, the State launched the 3-year pilot Keiki Care plan to provide free health insurance for children ineligible for Medicaid. However, in December 2008, the Governor halted the program due to budget constraints and poor performance (although advocates dispute this contention). The 2009 Legislature restored funding to the Keiki Care program to June 30, 2012 and requires health care services be delivered through federally qualified health centers. The appropriation was scaled back to $200,000 for each year of fiscal biennium 2009-2011 and will cover 600 kids annually, which is 30% of the previous Keiki Care enrollment. The Governor has announced she intends to veto the bill.

HCK continued outreach to laid-off workers with children by working with the State's Rapid Response Team, which provides information on services for large groups of laid-off workers due to company closures; posting a link on the State Department of Labor and Industrial Relations web page; and printing a message about children's health insurance on unemployment checks beginning May 2009. HCK health insurance information flyers are published in 21 languages to reach the multiethnic population.

HMSA, the state's largest medical insurer, has a Children's Plan for $55.00 a month per child.

Title V contracts require appropriate referrals for uninsured children who are eligible for Med QUEST. Out stationed eligibility workers are employed by community health centers and hospitals with Med-Quest funds.

c. Plan for the Coming Year

Data for this measure will be updated in next year's report. Hawaii continues to draw closer to the Healthy People 2010 goal of complete coverage for all. Objectives will be revised since it is unlikely Hawaii will reach zero uninsured children by 2010, especially with the state's economic downturn.

The impact of the State's poor economic conditions has resulted in increased unemployment. Because the main source of coverage in Hawaii and the U.S. as a whole is employment-based insurance, the coverage situation has deteriorated as unemployment has risen. Future data may begin to reflect this impact.

Cuts to state-funded safety net services and positions have begun and will likely continue into the next fiscal year as the budget deficit mounts. The impact of budget cuts on the State Medicaid program is unclear at this time.

The Title V agency will continue to work in partnership with HCK and stakeholders to expand outreach and enrollment of uninsured children and youth. All Title V purchase-of-service contracts will continue to require that eligible uninsured children be referred for appropriate health insurance coverage.

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	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			22	22	21
Annual Indicator	23.5	22.4	22.4	21.5	21.4
Numerator	3670	3500	3500	3215	3447
Denominator	15616	15624	15624	14952	16106
Data Source					Data Source (numerator, denominator): Hawai‘i Stat
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
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20	19	18	17	17

Notes - 2007
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" according to the CDC. The problems have been addressed and data is being resubmitted. The current 2007 data is being reviewed by CDC.

Notes - 2006
This is a new National Performance Measure added in for the five-year report period, FY 2006-2010.

Data is from the Supplemental Nutrition Program for Women, Infants and Children (WIC), Department of Health.

a. Last Year's Accomplishments
The data for 2008 indicates 21.4% of WIC children age 2-5 years were overweight or at-risk for overweight. The State objective was nearly met. The 2008 reflects a slight decline in the rate of overweight among WIC children. The estimate in Hawai‘i remains significantly lower than the national average of 31.3% for states reporting PedNSS data. The significance of the decline in Hawai‘i rates in the light of increased rates shown in other data sources is uncertain and will be monitored.

WIC staff monitor length and weight on infants and children up to age 2 and height/weight ratios (Body Mass Index) on all 2 to 5-year-olds to assess whether they are in a healthy range. WIC dieticians and certified staff counsel on the risk of childhood weight gain and explore ways to make recommended changes in diet and activity with caregivers.

WIC continued to provide staff mentoring on the Participant Centered Education (PCE) approach to ensure counseling effectiveness. Advanced PCE staff training continued this year. WIC also provided training to designated local agency staff on mentoring techniques to ensure on-going

quality assurance and guidance for staff utilizing PCE.

WIC directed efforts to assure the decreasing child overweight rates continue to decline. WIC continued to look for innovative ways to encourage healthy eating and physical activity for children ages 2-5 as well as for the entire family (i.e., development of lesson plans, curriculum or even purchasing of activity mats or other toys). An upcoming revision of food packages will allow the purchase of fruits and vegetables.

The Division ensures individuals (including children) who do not have health insurance have access to primary health care services by contracting with service providers throughout the state. Contractors are required to measure BMI ratios of children and adolescents to identify children who are overweight or at-risk for becoming overweight and are referred for treatment/support services. Title V continued to monitor BMI data submitted on annual reports by the service providers.

In February, 2008, Title V sponsored training for pediatric providers, EPSDT coordinators and Title V staff on the "Hawaii Pediatric Weight Management Toolkit." The Pediatric Foundation of Hawaii and the Hawaii Chapter of the American Academy of Pediatrics, (HAAP) released the "The Hawaii Pediatric Weight Management Toolkit" at HAAP's Pediatrics Island Style conference.

A local pediatrician and dietician developed the toolkit to help providers implement recent national recommendations concerning evaluation and treatment of overweight children and adolescents. The tool kit includes worksheets to assess the child's medical history, activity and nutrition; behavioral tip sheets to review with a parent and child; and pages that parents are asked to fill out with information about the child. Behavioral changes are suggested in 5 areas: reducing sugar-sweetened drinks, reducing sedentary activities, developing a strategy to deal with fast foods, encouraging more physical activity and alternatives to white rice (a staple in many families locally). WIC staff have also been trained on the toolkit.

The Hawaii Health Initiative (HHI) continues to be the DOH lead to increase physical activity and healthy eating among all Hawai'i residents. Title V (including WIC) participated as part of a multi-disciplinary group of private and public stakeholders that developed the "Hawai'i Physical Activity and Nutrition Plan" in 2007.

HHI formed a statewide Physical Activity and Nutrition (PAN) Coalition that developed working objectives now being implemented by county PAN coalitions. The Hawaii PAN Plan has an objective and strategies to strengthen systems to provide physical activity and nutrition in preschool and childcare facilities. Title V (including WIC) participates in the Coalition workgroup.

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. Assess 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		
4. Implement action plans related to diet and physical activity.	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 as part of the PedNSS.				X

7. Collect data on children's BMI from the Community Health Centers.				X
8. Develop and implement the Statewide Obesity Prevention Plan including sections concerning young children.				X
9. Promote healthy lifestyles through public education campaigns.			X	
10.				

b. Current Activities
WIC implemented a revised assessment tool to thoroughly assess a family's overall eating habits. The tool focuses on the quality of the individual's diet (not based on a 24 hour recall). Assessment revisions include non-nutrient dense beverages; whole versus refined grains; and energy dense, but not nutrient dense foods.

Counseling protocols for WIC children ages 2-5 years old who are at a BMI of 85th% or greater now include consistent recommendations and goals utilized in the Hawaii Pediatric Weight Management Toolkit.

The new WIC food packages effective October 1, 2009 include reduced fat milk, fruit/vegetables, whole grains, baby foods and soy alternatives. Training and educational materials were developed to assist participants in the selection and purchasing of lower-fat milk, fruits/vegetables and other new food items. 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. Staff and community partners were introduced to the changes at the WIC State Conference in May 2009. Participant education on the changes will begin in August 2009.

Title V will continue to monitor the BMI data reported annually by the contracted providers for primary care services for the uninsured.
As part of the Title V Needs Assessment, child obesity was identified as a continuing state priority issue. Stakeholder input was collected from a survey distributed in 2009.

c. Plan for the Coming Year
WIC will continue implementing the new food packages which support healthier food choices with on- going development of educational materials to assist participants in the selection and purchasing of fruits and vegetables, reduced fat milk, and whole grain foods. Materials will support the messages of lowering saturated fat intake and choosing whole grains. Reduced fat milk will be the standard for adults and children 2 and older. The list of WIC-approved cereals will be at least 50% whole grain.

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 will be offered a kit which includes a family guide and DVD that shows Sesame Street characters modeling healthy behaviors.

To address state budget shortfalls, the Governor is proposing 3-day per month furloughs for all state employees including. WIC state employees. This may potentially reduce the caseload served by 1000-2000 participants each month at a time when WIC caseloads are generally increasing due to the state economic downturn. Although the purchase-of-service agencies may be able to absorb some caseload, there are no options for Kauai or certain parts of Oahu, Maui and the Big Island.

Title V will continue to monitor the BMI data reported annually by the contracted providers for primary care health services for the uninsured and ensure the providers discuss prevention

education and strategies with families and communities.

The Physical Activity and Nutrition (PAN) Coalition has been renamed to the Nutrition and Physical Activity Coalition (NPAC). NPAC activities include developing curriculum and educational information, promoting nutrition/physical activity guidelines and policies, supporting breastfeeding and educating parents and childcare providers.

Since child obesity was selected as a state priority as part of the Title V needs assessment, a problem analysis will be conducted to evaluate progress to date, identify major risk/protective factors, and assess the existing service system. Strategies will be identified at a statewide stakeholders meeting in November 2009.

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	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			8	8	7
Annual Indicator	8.1	8.4	9.4	8.4	8.4
Numerator	1420	1440	1716	1548	1548
Denominator	17633	17233	18300	18504	18504
Data Source					Data Source (numerator, denominator): Hawai‘i Stat
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
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6.8	6.5	6.2	5.9	5.9

Notes - 2008
Data for the year 2007 is the latest data available.

Notes - 2007
This is a new National Performance Measure added in for the 5-year reporting period, FY 2006-2010.

Data for this measure comes from the Pregnancy Risk Assessment Monitoring System (PRAMS). The Hawaii Department of Health (DOH) started PRAMS in June 1999 as a pilot project. The year 2000 is the first full year of PRAMS data. Data for the year 2006 is the latest available data for women who smoke in the last 3 months of pregnancy.

Notes - 2006
This is a new National Performance Measure added in for the 5-year reporting period, FY 2006-2010.

a. Last Year's Accomplishments

Smoking is the single largest known preventable risk factor for poor pregnancy outcomes. The 2007 data (latest available data) indicates 8.4% of pregnant women reported smoking during pregnancy. The State objective of 7.6% was nearly met. The Healthy People 2010 objective of 1% was not met.

PRAMS analysis on data for 2004-06 shows that 20% of women report smoking prior to pregnancy with only 9% continuing to smoke during pregnancy. However, only a third remained smoke free in the postpartum period when infants can suffer respiratory afflictions and other health problems related to second hand smoke. Maternal characteristics related to women that continue to smoke during pregnancy are: Medicaid insured; unmarried; of Samoan or Hawaiian ethnicity; reside on the Big Island; a high-school graduate or less; and, pregnant for the four or more time.

Title V continues to administer the Perinatal Support Services (PSS) and Baby Substance Abuse Free Environment (SAFE) programs that provide outreach, screening, health education, case management and care coordination for high-risk and substance-using pregnant women. The PSS and Baby SAFE providers have received smoking cessation brief intervention and advanced motivational interviewing training to support clients to make healthier behavioral choices. The programs use the Brief Intervention methods when initiating support services at community clinics and WIC locations since it helps to engage poly-substance using pregnant women to participant in the PSS and Baby SAFE programs.

The federal Healthy Start Big Island Perinatal Disparities program (BIPDP) was implemented through a purchase of service contract with a community provider. The program screens pregnant women for smoking, alcohol and drug use, domestic violence and depression to decrease the incidence of poor birth outcomes on Hawaii Island.

Title V contracts with the Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii to operate the MothersCare website and phone line to provide information on health issues and perinatal resources, including smoking cessation. HMHB also conducts Smoking Cessation Brief Intervention (BI) training and an Advanced Train-the-Trainer series statewide for perinatal providers. In 2008, 6 providers completed the BI training while 11 providers completed the instructor certification. HMHB continues to promote the state smoking Quitline among pregnant women.

Title V co-chairs a Prenatal Smoking Workgroup comprised of public and private smoking prevention and perinatal programs. In the 2008 the workgroup supported introduction of legislation requesting the Department of Human Services (DHS), the state Medicaid agency, to study the feasibility of implementing a smoking cessation benefit to Medicaid enrollees all including pregnant women. The workgroup also provided guidance on the selection of smoking questions for the 2009 PRAMS Survey to the PRAMS Steering Committee.

The WIC program screens clients for smoking during pregnancy and makes referrals for further assistance at the initial client visit. Some WIC clinic locations collaborate with PSS and Baby SAFE staff to conduct smoking cessation brief intervention screening for their clients.

Hawaii is one of the last 46 states that dedicate a portion of funding received from the 1998 Tobacco Settlement to smoking prevention. The Tobacco prevention and control programs include the statewide Quitline, an aggressive media campaign, social norm change through policy development and coalition activities, surveillance/evaluation, and a community grants program. Strong advocacy and public education have led to comprehensive tobacco control laws; increases in cigarette taxes, sales restrictions to minors, and smoke free workplaces. Reducing smoking during pregnancy and during the postpartum period are objectives in the State Tobacco

Prevention Plan.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	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 high-risk pregnant women statewide.	X	X		X
3. Execute and administer contracts for outreach and pretreatment services to pregnant women using tobacco and other drugs.	X	X		
4. 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		
5. 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
6. Provide screening and referral for WIC low income perinatal clients who use substances including tobacco.		X		
7. Support training on smoking cessation interventions for perinatal service providers.		X		X
8. Continue needs assessment efforts through the Prenatal Smoking Workgroup to promote strategies that work in smoking cessation for women before, during and after pregnancy.				X
9. Collaborate on effective strategies to reduce smoking during and after pregnancy as part of the State Tobacco Use Prevention and Control Plan (e.g. media, counter marketing campaigns, policies for smoking prevention and control use, surveillance and				X
10. Operate the statewide toll-free smokers Quitline.			X	X

b. Current Activities

The Title V program co-sponsored a Perinatal Summit held on the Big Island in October 2008. The Summit served as a platform to highlight state perinatal data and issues in perinatal health including substance use during pregnancy. A publication of perinatal fact sheets was developed by Title V for the Summit including a fact sheet on perinatal substance use (including smoking).

The Title V PSS, Baby SAFE, BIPDP services continue. Since 2007, all perinatal service programs report whether clients smoke as a risk behavior. The program data for PSS showed that 24% smoked during pregnancy.

Due to State budget restrictions by the 2009 State Legislature, the Baby SAFE program will be discontinued on July 1, 2009.

The Prenatal Smoking Workgroup continued advocacy in the 2009 State Legislature for a resolution requesting the DHS to study the feasibility of implementing smoking cessation opportunities for Hawaii Quest beneficiaries. This measure was passed with certified copies sent to the DHS Director, Senate and House Human Services Committee Chairs.

HMHB continues to promote utilization of smoking cessation resources among pregnant women. HMHB distributed Quit Kits to the OB/GYN faculty and staff at the Kapiolani Medical Center for Women and Children. The Quit Kits help direct women to the Quitline for personalized service in their efforts to quit smoking. HMHB provided training to 34 people in basic smoking cessation brief intervention.

c. Plan for the Coming Year

Data for PRAMS will be updated in the next year. The objectives for this measure have been set to decrease .5% every year to assure progress in achieving the Healthy People 2010 Objective.

Title V efforts will continue to focus on reducing smoking during pregnancy but also address increasing smoking cessation in the preconception period and reduce the resumption of smoking during the post-partum period.

Extension of the PSS contract for high-risk pregnant women will be executed for another two years, but due to state fiscal restrictions some PSS providers will receive less funding to provide support services.

Title V PSS and the Big Island Perinatal Disparities (BIPDP) program providers will continue to offer tobacco cessation services to high-risk pregnant women. With the termination of the Baby SAFE program and reduced PSS funding, perinatal providers will be challenged to address the gap in services with limited resources.

Title V will develop a web-based data collection system for perinatal service providers to replace the current hard-copy client reporting forms. The improved technology will increase efficiency for data entry and invoicing for services. Access to data for analysis, program evaluation and reports will be available to providers, including the prevalence rates of smoking during pregnancy and the interconception period.

HMHB will collaborate with Title V to address various perinatal issues including smoking during pregnancy.

The Prenatal Smoking Workgroup will continue to meet and discuss opportunities to increase public awareness on the dangers of smoking in pregnancy, resources for smoking cessation among pregnant women and their families, and related legislation and policies.

WIC will continue to screen clients for tobacco use and provide appropriate referral as required.

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	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	5	9	9	8	8
Annual Indicator	8.2	8.2	8.2	10.6	10.6
Numerator	20	20	20	26	26
Denominator	245172	243426	243656	244971	244971
Data Source					Data Source (numerator): Hawai‘i State.

					Department
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.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7	7	7	7	7

Notes - 2008
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. Unstable measures are not useful in making decisions. Caution should be exercised in the analysis of the reported data.

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated death data file. Data for the year 2007 is based on a provisional death 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, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008). Objectives were revised based on the FY 1999 indicator. 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. Unstable measures are not useful in making decisions. Caution should be exercised in the analysis of the reported data.

Notes - 2006
Data is for resident population and is by calendar year. Data for the year 2005 was revised with an updated death data file. Data for the year 2006 is based on a provisional death data file. Population data based on U.S. Census Bureau, Population Estimates Program, SC-EST2006-AGESEX_RES: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2006. Release Date: May 17, 2007. Objectives were revised based on the FY 1999 indicator. 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.

a. Last Year's Accomplishments
Three-year averages were used to calculate the indicator of this measure because the numbers are small and vary substantially from year to year. The provisional data for the 2007-2008 indicator is 10.6. The state objective was not met.

The State Departments of Health (DOH) and Education (DOE) continue to support surveillance instruments on adolescent behavior including the Youth Risk Behavioral Survey (YRBS) for public high and middle school students. The survey includes questions on suicidal thoughts and behavior as well as protective factors. Compared to national YRBS high school students rates, Hawaii's youth had one of the highest rates for suicidal ideation in the U.S.

The DOH lead for youth suicide prevention is the Injury and Prevention Control Program (IPCP) which has a suicide prevention coordinator position. The 2007 Legislature appropriated $100,000

for programs to prevent the rising rates of youth suicide.

The Hawaii Suicide Prevention Task Force (SPTF) was formed in 2005 and is staffed by IPCP. 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. The Suicide Prevention 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.

With support from the SPTF, the first Suicide Prevention Conference was held in November 2007 with national speakers and well-known suicide survivors as presenters. More than 250 people attended the two day conference which included representatives from public and private agencies as well as other interested survivors and community members. Hawaii's media provided coverage for the event with poignant articles and stories to increase public awareness for the issue. Plans for the November 2008 Statewide Suicide Prevention conference began.

The SPTF reorganized its membership and conducts meetings every two months. Electronic bulletins on Task Force activities and other suicide prevention news are emailed to members and other interested individuals statewide. Title V is represented by the Adolescent Health Coordinator who serves as a part of a core group that was formed to address matters that require a more timely response.

In March 2008, the national Suicide Prevention Action Network (SPAN) USA recognized the past chair of the SPTF, Pua Kaninau, for her outstanding contributions to suicide prevention.

In October 2006 IPCS established a statewide system to train gatekeepers on each island to recognize and refer individuals at-risk for suicide to the appropriate level of care. The evidence-based Applied Suicide Intervention Skills Training (ASIST) model is used to train "Gatekeepers" and ASIST trainers. Gatekeepers are individuals in a community or organization who have face-to-face contact with large numbers of people as part of their routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate. Currently, there are 45 ASIST trainers statewide with 743 trained Gatekeepers.

IPCS worked with Mental Health America of Hawaii to support their Faith-based/At- Risk youth project. Ten discussion groups were conducted with teens ages 13-24 to explore the youth's thoughts and feelings about depression and suicide. Also discussed were coping mechanisms, risk and protective factors, and the role of faith and/or spirituality, culture and ethnicity in their perceptions of depression and suicide.

In February 2008, the DOE's 25 Peer Education Program (PEP) coordinators attended a presentation on suicide and suicide prevention.

The Hawaii Suicide Prevention Education Awareness Research (SPEAR) Foundation provides information on suicide awareness and prevention to high school students statewide and provides support to family survivors. This organization, formed by the family and friends of teens who have committed suicide, actively pursued organizing activities such as the annual suicide awareness walk, support services and a website with information that links to other suicide prevention resources. SPEAR is a key participant in the suicide prevention conference planning group and SPTF.

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 2005-2010 Hawai'i Injury Prevention Plan.				X
3. Develop greater coordination and collaboration to address suicide prevention.				X
4. dentify suicide prevention strategies by reviewing information surrounding child 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. Participate in Suicide Prevention Plan Steering Committee, Task Force, and sub-committee to address short and long term objectives of the plan with relation to adolescents.				X
10.				

b. Current Activities

The IPCP received a 3-year federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for $500,000 each year to support teen suicide prevention. The grant will be used to increase the number of adult gatekeepers in the DOE, DOH, the Honolulu Police Department (HPD), and other key agencies to reduce the number of completed and attempted suicides among at-risk youth ages 10-24. A new coordinator was hired by IPCP to administer this grant.

Mental Health America Hawaii received a grant from the National Institute of Mental Health to expand their speaker's bureau into a faith based community outreach program to address depression and suicide prevention.

The DOH Child and Adult Mental Health Divisions provide funding for ASIST gatekeeper training and continue to support training of their staff on all islands. The DOH mental health crisis phone line staff receives ASIST training as part of their orientation.

The 2nd annual Statewide Suicide Prevention Conference was held in November 2008. The National Center for Child Death Review (CDR) Director and the CDR Nurse Coordinator lead a conference session. In coordination with the suicide conference, the Hawaii CDR Council sponsored a training the day before the conference to maximize the availability of its national resource speaker.

c. Plan for the Coming Year

Title V continues to monitor data for teen suicide. Provisional data will be updated. Objectives are set for a 1% point reduction every two years based on the FY 2000 indicator.

The goal continues to be the reduction of completed and attempted suicides among youth ages 10-24 years of age by training adult gatekeepers in key agencies to recognize and respond to youth who are at risk.

This year Hawaii will join a cross-site evaluation database of thirty other state/tribal sites that receive funds from SAMHSA for teen suicide prevention under the Garrett Lee Memorial Act. The Hawaii Gatekeeper Training Initiative will begin to track program activity related to the early identification of youth at risk for suicide, referrals for services, service linkages as well as other program outcomes. The administrative details and implementation plan are currently underway.

The SPTF plans to continue efforts to prevent youth suicide and reduce ideation rates. The Suicide Coordinator position that staffs the SPTF was recently vacated due to retirement. Efforts to fill the position have not started since there is a hiring freeze for all state-funded positions due to increasing budget deficits.

The 2007 Legislative appropriation to support programs for youth suicide prevention ($100,000 for 2 years) is now part of IPCP's base budget, so continued program funding will be available to support future activities.

The Hawaiʻi Injury Prevention Plan (2005-2010) will be revised in the upcoming year to address infrastructure to prevent child injuries including suicide prevention.

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	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	86.9	87.5	88	88.5	89
Annual Indicator	88.7	89.3	88.5	89.5	84.7
Numerator	211	216	223	205	199
Denominator	238	242	252	229	235
Data Source					Data Source (numerator, denominator): Hawaiʻi Stat
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
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	89.5	90	90	90	90

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated birth data file. Data for the year 2007 is based on a provisional birth data file.

There are three medical facilities considered to be tertiary care centers in Hawaiʻi: 1) Kapiʻolani 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 - 2006
Data is for resident population and is by calendar year. Data for the year 2005 was revised with an updated birth data file. Data for the year 2006 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.

An annual pace has been blueprinted to meet the Healthy People 2010 objective for this measure.

a. Last Year's Accomplishments
Provisional data for 2008 indicate 84.7% of very low birth weight infants were delivered at facilities for high-risk deliveries and neonates. The objective was not met. Although the rate did drop from last year, the data is provisional. Hawaii did not meet the Healthy People 2010 objective of 90%.

Hawaii has no formal designation of Neonatal Intensive Care Unit (NICU) by level. Based on capabilities of Level III centers nationwide, Kapiolani Medical Center for Women and Children (KMCWC) and Tripler Army Medical Center report themselves as Level III. Kaiser Medical Center has the capacity to handle most high-risk deliveries, caring for premature ventilated babies in their own NICU. Kaiser does not transfer mothers out to other facilities based on risk of delivering a low birth weight baby, but do not declare themselves Level III because of certain gaps in pediatric subspecialty services.

Tertiary care centers are located only on the island of Oahu. There is limited access to specialty obstetric care on the neighbor islands and rural Oahu for high-risk pregnant women. High-risk deliveries are usually directed to Level III hospitals when necessary and neonates requiring NICU care on the neighbor islands are flown by air ambulance in an emergency to Oahu. Pregnant women and neonates with Medicaid coverage are covered for air and ground ambulance services.

No deliveries occur on Lanai with the exception of precipitous deliveries. Pregnant women on Lanai plan for delivery on the islands of Oahu or Maui. On Molokai, certified nurse midwives provide perinatal care to pregnant women and perform low-risk vaginal deliveries on the island; all high-risk or cesarean section births occur on Oahu or Maui. An obstetrician flies to Molokai twice monthly to see patients and provide supervision to the midwives.

Transport by air ambulance of high-risk obstetric cases from outlying neighbor islands to Level III hospitals on Oahu helps improve this objective. There are two air ambulance companies, AirMed Hawaii and Hawaii Air Ambulance. KMCWC uses AirMed Hawaii exclusively for high-risk obstetric, neonatal, and pediatric cases. The Hawaii Air Ambulance transports high-risk obstetric cases in partnership with the hospitals in Kauai, Maui, Hilo and Kamuela on Hawaii Island.

The Title V purchase of service (POS) contracts, continued to screen pregnant women for high-risk psychosocial, medical and/or behavioral issues, including substance abuse. Perinatal Support Services (PSS) and the Baby Substance Abuse Free Environment (Baby SAFE) program addressed contributing risk factors for preterm birth and low-birth weight neonates. With the renewal of the PSS contracts on July 1, 2007, new report forms were adopted to invoice by unit rate and improve data collection. In FY 2008, PSS served approximately 3,000 high-risk pregnant women.

Renewal of the Baby SAFE contracts also started on July 1, 2007 for one year due to plans to

revise program services.

Title V continued funding for the Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii to manage the statewide perinatal resource and referral phone line and MothersCare website. Through the perinatal information phone line and website, HMHB provided comprehensive perinatal resources to childbearing women and their families. HMHB also developed and facilitated a Perinatal Advocacy Network to keep perinatal stakeholders informed and current on issues for improvements to the Hawaii perinatal system of care.

The Perinatal Addiction Treatment of Hawaii (PATH) Clinic received funding from the State legislature to provide comprehensive prenatal and postnatal care to substance using pregnant women. The PATH Clinic provides both clinical and social support services and is administered by University Department of Obstetrics, Gynecology and Women's Health faculty.

The federal Healthy Start Big Island Perinatal Disparities program (BIPDP) was implemented through a purchase of service contract with a community provider. The program screens pregnant women for smoking, alcohol and drug use, domestic violence and depression to decrease the incidence of poor birth outcomes on Hawaii Island.

Analysis of the Hawaii Pregnancy Risk Assessment Monitoring System (PRAMS) data continued to provide population-based data on pregnancy behaviors of recently delivered mothers to improve perinatal program services and goals, to reduce the incidence of low-birth weight infants and high-risk deliveries.

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. Execute and administer contracts for perinatal support services to assure access to services for high-risk pregnant women statewide.	X	X		X
3. Execute and administer contracts for outreach and pretreatment services to substance abusing pregnant women.	X	X		X
4. Administer the federal Healthy Start grant for the Big Island Perinatal Disparities program to provide outreach and support services for high-risk pregnant women assure access to care and reduce poor birth outcomes like low birth weight.	X	X		X
5. 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
6. Assure access from the neighbor islands to tertiary care centers through the air ambulance system.				X
7. Support efforts to improve coordination and collaboration among perinatal providers.				X
8. Support community based efforts and advocacy for actions and policies which improve access to primary care, perinatal care and perinatal support services.				X
9. Promote partnerships to assess, address and improve upon policies and practices which can positively impact perinatal, prenatal health services and high risk deliveries.				X
10.				

b. Current Activities
The Baby SAFE contracts will end on June 30, 2009 due to funding restrictions by the 2009 Legislature. Alternative funding is being sought to maintain the program. DOH Alcohol Drug Abuse Division (ADAD) also contracts for somewhat similar services for pregnant and parenting women.

Funding for the PSS contracts was also impacted by funding restrictions by the 2009 Legislature and will likely result in a reduction of services for the next State biennium.

The BIPDP continues to address priority objectives: increase entry into first trimester care, reduce the incidence of VLBW infants and infant mortality rates on Hawaii Island.

In October 2008, DOH MCH Branch, the March of Dimes (MOD) with HMHB hosted a Perinatal Summit on Hawaii island. A compendium of fact sheets on perinatal health issues developed by the Title V agency was distributed. The data reported indicated an increase in cesarean deliveries from 1999-2006 and also found women with a primary C-section had a higher incidence for a low birth-weight infant. The data was used to help with passage of a legislative resolution calling for a study on C-sections and induced deliveries in the State.

AirMed Hawaii, Kapiolani Medical Center transport team and the Collaborative Health Initiative on Hawaii Island will partner to develop "neonatal resuscitation teams" on the neighbor islands to improve patient safety and standard of care for neonatal resuscitation, pre-term labor, and aeromedical transfer.

c. Plan for the Coming Year
Objectives for this measure were set to achieve the HP 2010 objective of 90% in 2010. Provisional data for 2007 will be updated.

The PSS programs will be extended for an additional two year contract but will have funding reduced.
Perinatal Providers will have to make adjustments for substance-using pregnant women with the loss of the Baby SAFE programs. It is anticipated that resources through the DOH Alcohol Drug Abuse Division (ADAD) will be available to continue addressing substance abuse in pregnant and parenting women. ADAD receives federal funding to address substance abuse and offer treatment services.

An interdepartmental stakeholders group was convened in 2009 by the State Senate Human Services Committee Chair with HMHB to address health and support services following delivery as well as prenatal and interconception care. Members include Title V, Department of Human Services, health care plans, health care providers, March of Dimes Hawaii Chapter, and the American College of Obstetrics and Gynecology. The group will continue to meet with support from HMHB. This partnership is beginning discussions at a critical time with the reduction of services and resources due to the state fiscal crisis. Collaborative strategies may help to maintain the quality and availability care despite the increasing demand for safety net services. The participants are starting to share data, program information, and identify common concerns. It is anticipated this forum can serve as a foundation to improve the system of care for perinatal health and improve outcomes for high risk deliveries.

As noted, the 2009 Legislature passed Resolution 215 that requests DOH to assess the policies and procedures implemented by hospitals to reduce elective cesarean sections and induction of labor. A workgroup was convened in June 2009 to review and assess: 1) criteria used by hospitals and physicians for indications used for elective inductions or cesarean sections; and 2) policies and procedures implemented by hospitals to reduce elective cesarean sections and

induction of labor. Partners with Title V in this assessment are MOD Hawaii Chapter, HMHB, and the Healthcare Association of Hawaii, the non-profit organization representing Hawaii's acute care hospitals and other community-based health providers. A report on these findings will be submitted to the 2010 Legislature.

The BIPDP will continue to address priority objectives: increase entry into first trimester care, the reduction of low birth weight infants and infant mortality rates. Four local area consortiums were established to increase access to prenatal care and improve birth outcomes such as low birth weight infants.

HMHB will continue to manage the statewide pregnancy resource and referral phone line and website. HMHB will also continue to conduct statewide perinatal needs assessment and facilitate meetings and trainings for perinatal providers and stakeholders.

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	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	86	81	82	83	84
Annual Indicator	79.0	79.1	79.0	77.9	79.9
Numerator	14417	14151	14957	14868	15514
Denominator	18242	17882	18927	19086	19408
Data Source					Data Source (numerator, denominator): Hawai‘i Stat
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
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	85	86	86	86	86

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated birth data file. Data for the year 2007 is based on a provisional birth data file.

Notes - 2006
Data is for resident population and is by calendar year. Data for the year 2005 was revised with an updated birth data file. Data for the year 2006 is based on a provisional birth data file.

The performance measure objectives have been revised based on the FY 2003 indicator.

a. Last Year's Accomplishments
Provisional data for 2008 indicates 79.9% of pregnant women received first trimester prenatal care (PNC). The state objective of 84% was not met nor did Hawaii meet the Healthy People

2010 objective of 90%.

Title V staff provide overall management and administration of Perinatal Health Programs and the Pregnancy Risk Assessment Monitoring System (PRAMS). The Perinatal Support Services Programs (PSS) provides services for high-risk pregnant women at 10 sites throughout the state serving roughly 3,000 women annually. The first year of the new contract period used a unit rate cost reimbursement for services. New reporting forms were also adopted to improve client data, track utilization and initiation of prenatal care. Analysis of data found that 53% of PSS clients started PNC in the first trimester.

In September 2008, PSS contract providers received motivational interviewing and brief intervention training to enhance counseling skills in working with high-risk pregnant women.

Title V staff administers the Baby SAFE service contracts to provide outreach to substance-using pregnant women and encourages early prenatal care. A request for proposal process resulted in modifications of the FY 2010 Baby SAFE service contracts to expand program services to include a triage component to enable providers to make referrals and provide resources for substance-using pregnant women and encourage first trimester PNC.

The federal Healthy Start Big Island Perinatal Disparities program (BIPDP) offers supportive services to high-risk pregnant women on Hawaii Island. Outreach is targeted toward populations that generally do not access prenatal care services specifically Native Hawaiians, other Pacific Islanders, Hispanics and adolescents.

Entry into early PNC is one of the performance measures used to evaluate the PSS, Baby SAFE and BIPDP contracts. To improve PNC rates, a higher unit rate reimbursement is awarded to PSS providers for pregnant women seen in the first trimester of pregnancy.

The Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii facilitates the PSS quarterly meetings and trainings to improve the perinatal system of care. HMHB also now manages the pregnancy resource, referral, information phoneline and website called MothersCare. The MothersCare phoneline and website assist pregnant women seeking MedQuest and/or an OB/GYN. This resource provides an opportunity for encouraging first trimester PNC.

HMHB is also contracted to conduct statewide perinatal needs assessment. The recent assessment completed by HMHB found the primary issue for the neighbor islands continues to be the lack of perinatal providers which impacts women's ability to access early PNC and specialty care. HMHB also continued to track perinatal legislative issues and monitor the Medicaid application process for pregnant women to reduce unnecessary delays.

The lack of OB and PNC services to rural and neighbor island communities are indicative of the high liability and operating costs for providing services. Families losing health insurance due to the poor economy and job loss also have an impact on the early prenatal care rate.

The Perinatal Addiction Treatment of Hawaii (PATH) clinic for substance-using pregnant women continued to provide comprehensive perinatal clinical and social services to women with a history of substance abuse despite funding shortfalls. Supported by a 2007 state appropriation, the PATH program director is seeking other funding sources to sustain services.

The Kalihi-Palama Health Center (KPHC) on Oahu began prenatal care groups using the three Centering Pregnancy concepts of PNC: assessment, education, and support. The groups are used to encourage women to take responsibility for their care and to interact effectively with the health care system. KPHC reports that immigrant pregnant women prefer this approach to care and are more likely to keep prenatal appointments when served within a group of women with similar cultural background. The project is funded by the March of Dimes Hawaii Chapter.

PRAMS data was one of the primary sources used in a Title V publication of perinatal fact sheets. The publication was distributed at a statewide Perinatal Summit held on Hawaii Island in October 2008. PRAMS data on PNC found that women who were less likely to obtain early care were Hispanic, Hawaiian, Samoan, or other Pacific Islander, younger in age, less educated, unmarried, and had Medicaid/QUEST insurance or were uninsured.

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, and Baby S.A.F.E. program data.				X
2. Execute and administer contracts for perinatal 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 of sources in areas with populations of higher risk women to improve access to prenatal care.		X		X
5. 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
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.		X		X
7. Continue state perinatal partnerships for assessment and advocacy in improving first trimester prenatal care access issues.				X
8. Support training opportunities for perinatal health providers.				X
9.				
10.				

b. Current Activities

The PSS providers, particularly at community health center sites, continue to assist uninsured pregnant women with completion of MedQuest applications and to initiate early prenatal care (PNC). A PSS provider on Oahu was able to provide services to the rural North Shore area which should help to improve early PNC.

Baby SAFE services for substance-using pregnant women will end on June 30, 2009, due to State funding restrictions.

The federal Healthy Start BIPDP continues to employ Neighborhood Women for outreach to the targeted at-risk populations to improve access to first trimester prenatal care. Local area consortiums also work on improving service delivery and action plans to increase access to care.

The PATH Clinic received small grants to continue their services and are anticipating federal grant funding from the CDC and the Health Resources and Services Administration.

The KPHC continues to conduct the Centering Pregnancy prenatal care groups for women. Participants are grouped by similar delivery date and cultural background.

HMHB conducted PSS provider trainings to improve cultural understanding of people from the Republic of Marshall Islands (RMI) and the Federated States of Micronesia (FSM). Featured speakers were professional women from RMI and FSM that provided information on the cultural beliefs and behaviors during pregnancy of this population group. These groups are often reluctant to seek PNC.

c. Plan for the Coming Year

The performance measure objectives have been set based on the FY 2003 indicator with a 1% increase annually. Provisional 2007 data will be updated next year.

Extension of the PSS contract for high-risk pregnant women will be executed for another two years, but due to fiscal restrictions some PSS providers will receive less funding to provide support services.

With the end of the Baby SAFE contracts to assist substance-using pregnant women, Title V staff will have to collaborate and rely on existing resources for substance abuse prevention and intervention services for pregnant women.

The federal Healthy Start BIPDP will continue to target the Hawaiian, Pacific Islander, Hispanic and adolescent populations and use neighborhood women to outreach to those groups.

Act 2, Section 2 passed in 2008 which required the Department of Human Services to report to the Legislature on the Centers for Medicare & Medicaid Services (CMS) response to Hawaii's request to extend post-partum and interconception care from eight weeks to at least six months for enrollees. Although the extension was not approved by CMS a workgroup spearheaded by the State Senate Human Services Chair and HMHB is meeting to assess perinatal health issues including improving service delivery during and following birth.

This newly formed group has representatives from Title V Department of Health, State Department of Human Resources (DHS), Community Health Centers, insurers (Hawaii Medical Services Association, Aloha Care), March of Dimes Hawaii Chapter and HMHB Coalition of Hawaii, and the American College of Obstetricians and Gynecology (ACOG). Current discussions include supporting early prenatal care for uninsured pregnant women and continuation of care following delivery during the interconception and preconception periods. Those serving clients such as immigrant pregnant women from the FSM and RMI states find common challenges such as misplacing documentation critical to qualify for MedQuest medical insurance.

The group is also utilizing the Perinatal Fact Sheet compendium published by Title V to facilitate its discussion on perinatal and women's health issues. It is anticipated this group will continue to meet over the next year and has the potential to address both program practice and policies to improve the system of prenatal care services.

The Hawaii PRAMS datasets will be updated for 2008 and entry into prenatal care data analyzed.

Healthy Mothers Healthy Babies Coalition of Hawaii will continue to monitor the amount of time it takes for uninsured pregnant women to become eligible for MedQuest insurance and collaborate with DHS on this issue.

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	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			48	47	46
Annual Indicator	49.6	52.4	52.3	52.9	52.9
Numerator	10820	11329	12046	12108	12108
Denominator	21816	21636	23016	22880	22880
Data Source					Data Source (numerator): Hawai‘i State. Department
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	45	44	43	42	42

Notes - 2007
Data for this measure comes from the Hawai‘i Pregnancy Risk Assessment Monitoring System (PRAMS). The Hawai‘i State Department of Health started PRAMS in June 1999 as a pilot project. The year 2000 is the first full year of PRAMS data. Data for the year 2006 is the latest data available.

PRAMS provides surveillance of unintendedness in pregnancies that resulted in a live birth and is used with vital records in Hawaii (as well as several other states) to calculate this measure. The PRAMS rate alone underestimates unintendedness prevalence as it does not include those pregnancies that ended up as an abortion, which are very likely to have been an unintended pregnancy.

Notes - 2006
This is a new State Performance Measure added in for the 5-year reporting period, FY 2006-2010.

Data for this measure comes from the Hawai‘i Pregnancy Risk Assessment Monitoring System (PRAMS). The Hawai‘i State Department of Health started PRAMS in June 1999 as a pilot project. The year 2000 is the first full year of PRAMS data. Data for the year 2005 is the latest data available.

a. Last Year's Accomplishments
This measure reflects the State priority to reduce Hawaii's rate of unintended pregnancies. The 2007 data (last available) indicates 52.9% of pregnancies in the State were unintended. The objective was not met, nor was the Healthy People 2010 objective of 30%. The unintended rates for this measure have been relatively stable over the past 5 years.

There is no national comparative data for the Title V unintended measure used by Hawaii as it requires inclusion of fetal deaths and abortions. Using 2002 PRAMS data (last available national data) Hawaii's unintended rate (43.2%) was comparable to the range reported by other PRAMS states (32.5% -54.3%).

Access to contraception can reduce unintended pregnancy rates but is not the only factor in prevention. The prevalence of contraceptive use among unintended pregnancies increased from 42.7% in 2000 to 52.2% in 2006 according to PRAMS data. The most frequent reasons given for not using contraception among unintended pregnancies were: did not mind if they got pregnant, problems getting birth control, husband/partner not wanting to use contraception, and other reasons (e.g. side effects, didn't think could get pregnant).

Hawaii's employer-based health insurance law mandates health plans to provide contraceptive supplies and services, but plans may offer limited options.

The 2007 State Legislature appropriated an additional $1.2 million of funding for family planning (FP) clinical and contraceptive services. An additional $463,587 Temporary Assistance to Needy Families (TANF) funds were appropriated for expanded community health education and outreach services to increase awareness and utilization of clinical services. A memorandum of agreement between the Department of Human Services, the state TANF agency, and DOH was executed to permit the interdepartmental transfer of funding.

Prevention of unintended pregnancy continued by providing greater access to contraception through conveniently located, publicly supported FP services. Thirty-nine clinic locations on 6 islands provided services through the federal Title X program. 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. The DOH is the only Title X grantee for Hawaii contracting with community health centers, college health centers, and physicians in rural areas for subsidized FP clinical and health education (HE) services. There are no State or county operated FP clinics in Hawaii. The Title X family planning program (FPP) is part of the Title V agency.

In FY 2007, 14,538 clients were provided subsidized FP clinical services over 23,158 clinical visits; of these 7,135 were uninsured (served over 10,988 visits). Approximately 26% of visits (1,719 clients) were for a positive pregnancy test noted as an unplanned pregnancy. On these visits 4.6% reported there was a "method failure" and 21.3% reported "no method" used.

Enabling services by contracted providers included case management, language translation and FP HE. Referrals to FP services were made for clients from other Title V programs.

The Male Achievement Network (MAN) Project offered through the Waikiki Health Center provides outreach and educational counseling services to males most likely to engage in risky sexual behaviors including incarcerated youth and those attending alternative schools for at-risk youth. The Project reached 708 high risk males in FY 2007.

Population-based services were provided through Title X statewide family planning (FP) community health educators (HE). Activities included school presentations, distribution of educational materials, and health fairs. The HE program made 32,283 direct contacts (individual or group sessions), of which 11,363 (35%) were to schools; and 440,704 indirect contacts (health fairs, exhibits, media information). With the additional FP funding community health educators worked with the area FP clinics to improve access to services.

The FPP sponsored "Family Planning Basics: Training of Trainers" and "Advanced Counseling Beyond the Basics" for family planning counselors. One hundred ten FPP providers and reproductive health experts attended the 27th Annual Family Planning and Reproductive Health Conference "Celebrate Reproductive Health" an event also promoting Hawaii Women's Health Week.

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 Title X funded contractors.				X
5. Provide reproductive health training and informational conferences for contractors and other providers.				X
6. Conduct the Title V needs assessment to evaluate the progress made on unintended pregnancy, refine the problem analysis, and identify strategic areas where improvement is feasible with stakeholders.				X
7. Support Women's Health activities including the promotion of the importance of preventive screening and check-ups.			X	X
8.				
9.				
10.				

b. Current Activities

Services described in the previous section continue despite cuts made to the State's FP funding. General funds for clinical services were cut $279,246 and TANF funds for health education were reduced by $55,631. Fortunately, the shortfall for clinical services was covered by supplemental Title X funds. Health education services contracts were reduced. In FY 2008, FPP served 18,954 clients.

Education and outreach services were increased for Kauai and in high risk communities on Oahu. There are 14 health educators, 11 are located at FP clinical service sites. There were 91,188 direct and 1,174,564 indirect education contacts.

Hawaii Youth Services Network, a coalition of statewide organizations serving youth, and Department of Education, held a teen pregnancy prevention (TPP) conference. The 250 teachers and professionals who attended received FP education and training on science-based TPP curriculum.

A fact sheet on unintended pregnancy was published by the Title V agency as part of a compendium of perinatal health issues. The document was distributed at a Perinatal Health Summit held in October 2008.

Title V Women's Health Program convened the Women's Health Week Committee of community partners to disseminate information on the importance of preventive health care and screenings (including reproductive health). Print media was distributed in stores, libraries, health centers, and health fairs. Health promotion messages were on bus placards and government pay stubs.

c. Plan for the Coming Year

Data will be updated next year. Objectives have been set to decrease by 1 percentage point per year.

FPP will continue to monitor contract sites and provide technical support. The FPP will continue to access to FP services in underserved geographical areas. It is unknown at the time of this report whether state budget cuts will affect FP funding.

The FP Health Education program will continue to collaborate with agency and community-based groups to educate people on the benefits of abstinence, delaying sexual intercourse, contraception options, and consistent condom use. The health educators are required to develop action plans and implement strategies to increase access to clinical service delivery for the population in-need. Health educators are also responsive to community, school and organizational requests for information.

FPP educates providers to utilize more varied and effective contraception methods in their practice to meet the needs of a diverse client population. In FY 2009, training focused on use of Implanon and new IUD methods and will continue next year. There are now 37 providers trained in Implanon insertion.

The FPP would also like to increase the availability of and access to vasectomy in each county, a recommendation from a recent Title X site review.

The MAN Project will continue to promote healthy reproductive decisions and use of contraception to high risk men.

To improve access to Emergency Contraception (EC), the EC website (ecHawaii.org) was merged into the Healthy Mothers Healthy Babies web site: www.hmhb-hawaii.org. EC is available at all FP provider sites and for women 18 and older at pharmacies statewide without a prescription.

Infrastructure building services will continue to focus on expanding partnerships to promote healthy youth development, teen pregnancy prevention, health education needs as well as improve family planning and perinatal health services. Risk factor and service data will be analyzed to improve service delivery. Joint trainings/meetings are planned for the FP contracted clinical providers and health educators to improve collaboration and service delivery.

The vacant PRAMS Coordinator position was filled in FY 2009. Further analysis of the unintended pregnancy data has been requested.

As part of the Title V Needs Assessment, unintended pregnancy was identified as a continuing state priority. Stakeholder input was collected from a survey distributed at the 2008 Perinatal Summit. A problem analysis will be conducted to identify major risk/protective factors and assess the existing service system. Strategies will be identified at a statewide stakeholders meeting in November 2009.

State Performance Measure 2: *Percent of infants with hearing loss who are receiving appropriate intervention services by age 6 months.*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			70	70	72
Annual Indicator	62.7	71.4	58.1	78.9	64.5
Numerator	37	50	36	45	40
Denominator	59	70	62	57	62

Data Source					Data Source (numerator/denominator): Hawai‘i State
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	74	76	78	80	80

Notes - 2007
For 2002-2004, the denominator is the number of infants with permanent hearing loss who did not pass the newborn screen. Beginning in 2005, the denominator is the number of infants with permanent hearing loss who did not pass the newborn screen minus infants who died or moved out of state after diagnosis, as reported to the state EHDI program for use in annual calendar year (CY) reports to the Centers for Disease Control and Prevention. The numerator is the number of diagnosed infants referred for Early Intervention services by 6 months of age. Data for CY 2005 and 2006 (Jan-Dec) were updated. Data for CY 2007 (Jan-Dec) are preliminary.

Notes - 2006
This is a new State Performance Measure added in for the 5-year reporting period, FY 2006-2010.

The denominator for this measure is the number of infants with permanent hearing loss who did not pass the newborn screen. The numerator is the number of these infants who were referred for Early Intervention services by 6 months of age. Data is reported by calendar year. Data for FY 2005 was updated. Data for FY 2006 is provisional and will be updated in next year’s report.

a. Last Year's Accomplishments
The 2008 indicator was 64.5%, which did not meet the objective of 72%. Preliminary 2008 data showed that of 64 infants diagnosed with permanent hearing loss, 2 families moved to the mainland after diagnosis. Of the remaining 62 infants, 40 received early intervention (EI) services before age 6 months, 12 received EI services after age 6 months, 2 refused EI services, and 8 were lost to follow-up/documentation (LFU/D). The CY 2008 data will be updated next year. Factors contributing to not meeting the objective include: redefining the numerator as the number of infants enrolled in, instead of referred to, early intervention (EI) services; change in staffing for the Newborn Hearing Screening Program (NHSP); lack of information about enrollment; and late enrollment in EI services after age 6 months.

NHSP began in 1990 through a law mandating that the DOH develop a 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. Amendment of the law in 2001 mandated screening all newborns for hearing loss and reporting screening results to the DOH. Hearing screening is now available to families statewide, regardless of birth location.

NHSP works with hospitals, physicians and other service providers to assist families in obtaining appropriate follow-up evaluations if their infant does not pass newborn hearing screening and in obtaining referral for Part C EI services if a permanent hearing loss is identified. Other programs and persons also refer infants with hearing loss to EI, although NHSP is not informed of these referrals without parental consent.

The DOH Early Intervention Section (EIS) provides EI services for children under age 3 years with special needs, including those with any type, degree, or laterality of permanent hearing loss. Families who refuse EI services may contact EIS at any time before their child's third birthday if they later decide they want services.

Starting in 2008, all parents were asked to sign a consent form to share information with NHSP at the time of enrollment in EI services. Matching of the EIS database of those who have signed consents and the NHSP database would help to identify children receiving EI services who had been lost to follow-up/documentation (LFU/D) for newborn hearing screening or evaluation. The data sharing and consent form would allow NHSP to identify and contact the EI care coordinators to confirm if appropriate diagnostic audiological evaluation and needed follow-up services were provided to these children who were originally LFU/D. This is expected to improve documentation related to the percentage of infants with hearing loss who are receiving EI services by age 6 months.

NHSP and EIS continued to collaborate with the American Academy of Pediatrics-Hawaii Chapter Early Hearing Detection and Intervention (EHDI) Champion to arrange educational training for pediatricians, speech pathologists, audiologists, social workers, public health nurses, and other providers.

EI Hearing Specialist assisted EI programs, providers, and families in serving children with hearing loss and made home visits. Working relationships continued with the Gallaudet University Regional Center, Hawaii Deaf-Blind Project, Hawaii Services on Deafness, Hawaii Center for the Deaf and Blind, and Kapiolani Community College American Sign Language (ASL) Interpreter Program. Partnerships with two cochlear implant teams continued.

Lending libraries have been established in each EI program, consisting of resources and curriculum for serving children with hearing loss and their families. In 2008, the lending libraries were expanded. The hearing aid and FM system loaner banks were also expanded.

Ohana Time informational family support meetings continued during 2008. Attending families networked with other families and learned more about community resources. The Deaf Mentor project continued to provide individualized family support in learning about Deaf culture, understanding the needs of infants with hearing loss, and learning communication techniques to foster language development.

Funding from the MCH Bureau for the Baby Hearing Evaluation and Access to Resources and Supports (Baby HEARS)-Hawaii Follow-Up Project supported NHSP efforts to improve newborn hearing screening and follow-up.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Inform families of infants w/ hearing loss about audiological evaluation and early intervention.		X		
2. Assist families in arranging needed audiological evaluations and transportation support.	X	X		
3. At family request, refer infants with permanent hearing loss for early intervention services.		X		
4. Provide consultation to early intervention staff on treatment planning for infants with hearing loss.		X		X
5. Develop lending libraries with videos and other materials on management and other aspects of hearing loss.		X		X
6. Conduct a Deaf Mentor Program on Oahu and monitor for developmental impact and family satisfaction.	X	X		X
7. Collaborate with other community deaf education services for families of infants with hearing loss.		X		X
8. Provide education, workshops, and training to improve				X

understanding of hearing loss and early intervention/other services.				
9. Monitor/track audiological evaluations results, hearing, amplification, and early intervention enrollment.				X
10.				

b. Current Activities
NHSP is improving its tracking and follow-up/coordination services for infants who fail inpatient or outpatient hearing screening/rescreening. NHSP is strengthening supports to hospitals and other providers in meeting the 1-3-6 EHDI timeline. Parent-to-parent support is provided to families with children who are in the process of being referred and to families with children with confirmed hearing loss. NHSP is participating in a newborn hearing screening Learning Collaborative to reduce loss to follow-up. NHSP now almost fully staffed to carry out program activities.

NHSP and EIS provide information about hearing, speech and language development to families of infants referred for EI. "Good Hearing Helps a Baby Learn to Talk" brochures were sent to EI programs in 12 languages and are available on the NHSP website. The "Sound Steps Hawaii State Resource Guide for Families of Children with Hearing Loss" has been reprinted and is available to EI programs and audiologists.

EIS provides EI services such as audiological evaluations and hearing aid related services for infants with permanent hearing loss. EIS has a procedure to support purchase of hearing aids with state funds upon family request. Children with Special Health Needs Program (CSHNP) also assists income eligible families with purchase of hearing aids. EIS and CSHNP maintain a hearing aid and FM system loaner bank. Ohana Time information family support meetings, the Deaf Mentor project, and Ohana Sign classes continue.

c. Plan for the Coming Year
NHSP will continue to refer infants with permanent hearing loss for EI services, and will monitor and track diagnostic audiological evaluations, confirmed hearing status, amplification, and EI enrollment status. Electronic matching will be established between NHSP and various EI databases to facilitate follow-up.

EIS will continue to provide EI services for infants with permanent hearing loss, including audiological evaluations, hearing aid related services and transportation support. CSHNP and EIS will continue to assist income eligible families with purchase of hearing aids for infants with permanent hearing loss.

NHSP and EIS will continue providing information about hearing, speech and language development to families of infants referred for EI. "Good Hearing Helps a Baby Learn to Talk" brochures and the "Sound Steps Hawaii State Resource Guide for Families of Children with Hearing Loss" will be disseminated. Education for health care providers will continue.

EI Hearing Specialist and contracted Deaf Educators will provide consultation and services for children under age 3 years with hearing loss and their families, and EI staff. The Deaf Mentor project and Ohana Sign classes will continue. Collaboration with Cochlear Implant centers, Hawaii Center for the Deaf and the Blind, the Gallaudet University Regional Center, and the Deaf-Blind Project will continue.

NHSP participates in the National Initiative for Children's Healthcare Quality's (NICHQ) Learning Collaborative B on newborn hearing screening. This one-year project focuses on reducing loss to follow-up in screening, evaluation and intervention through activities implemented at pilot sites. Activities planned include: develop care plan (roadmap) and other educational materials for families with infants who fail screening or evaluation, confirm contact information including a

second point of contact, improve communication with infants' medical home, and provide parent support to the Audiology Department of the pilot hospital. These activities will be implemented statewide if testing is successful at the pilot sites.

The EHDI Advisory Committee and its subcommittees will continue to meet and provide input on state program policies and procedures.

The Parent Coordinator will continue to provide support for families of children with hearing loss at the diagnostic and intervention stages of the EHDI process and to facilitate statewide family support activities. Ohana Time informational family support meetings will continue, with input from the Ohana Time planning committee. The hearing aid and FM system loaner bank will be expanded and additional lending library materials will be disseminated.

NHSP is applying for supplemental funding for activities that include improving follow-up coordination, roadmap to inform families of the follow-up process, updating hospital screening equipment, establishing community screening sites, and improving access to diagnostic services on rural islands.

State Performance Measure 3: *The percent of teenagers in grades 9 to 12 attending public schools who are overweight.*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			13	12	12
Annual Indicator	13.2	13.5	13.5	15.6	15.6
Numerator					
Denominator					
Data Source					Data Source (numerator/denominator): Hawai‘i Stat
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	11	11	11	11	11

Notes - 2008
The Hawai‘i Youth Behavior Risk Survey (YRBS) for Middle School is data weighted to the general population by the Centers for Disease Control and Prevention (CDC). YRBS is administered in odd-numbered years in Hawai'i's public middle and high schools. The extent of underreporting or over reporting of behaviors cannot be determined because information is self-reported. The data apply only to youth who attend Hawai'i's public schools and, therefore, are not representative of all persons in this age group.

Notes - 2007
The data comes from the Hawai‘i Youth Risk behavior Survey (YRBS). YRBS is administered in odd-numbered years in Hawai'i's public middle and high schools. The extent of underreporting or over reporting of behaviors cannot be determined because information is self-reported. The data apply only to youth who attend Hawai'i's public schools and, therefore, are not representative of all persons in this age group. The survey is conducted every two years.

Notes - 2006
The data comes from the Hawai‘i Youth Risk behavior Survey (YRBS).

a. Last Year's Accomplishments
This measure reflects the State priority to reduce rates of child/adolescent overweight. The 2007 Youth Risk Behavior Survey (YRBS) data showed 15.6% of high school youth were obese according to Body Mass Index (BMI) charts, a slight increase over the 2005 rate (however, the difference between the rates was not statistically significant). Hawaii's rate of 15.6% was higher than the national rate (13.0%). The state objective was not met; nor was the Healthy People 2010 objective (5%).

The Pediatric Foundation of Hawaii and the Hawaii Chapter of the American Academy of Pediatrics, developed the "The Hawaii Pediatric Weight Management Toolkit" in 2007. A local pediatrician and dietician developed the toolkit to help providers implement recent national expert recommendations concerning evaluation and treatment of overweight children and adolescents. Title V sponsored training sessions on the Toolkit for primary care health center providers, Early Periodic Screening Diagnosis and Treatment (EPSDT) coordinators and Maternal Child Health Branch (MCHB) neighbor island coordinators. The toolkit includes worksheets to assess a child's medical history, activity and nutrition; behavioral tip sheets to review with a parent and child; and pages that parents are asked to fill out with information about the child. The toolkit continues to be used by pediatricians, dieticians, WIC staff and public health nurses statewide.

HHI is the DOH lead to increase physical activity and healthy eating among Hawaii residents and focuses on three main areas to prevent chronic diseases in Hawaii: prevention of tobacco use; increasing physical activity; and improving nutritional habits.

HHI supported the development of the "Hawaii Physical Activity and Nutrition (PAN) Plan." HHI funds staffing for a state Nutrition and Physical Activity Coalition (NPAC) and neighbor island coalitions to implement the goals and objectives of the PAN plan. NPAC engages in infrastructure building, advocating systems changes, supporting legislation, and coordinating community efforts according to the PAN goals. State subcommittees include: school health, workforce, built environment, health system and nutrition. Title V staff participate in the state and neighbor island coalitions.

HHI implemented the USDA Food Stamp Nutrition Education Network program in Hawaii. The federal reimbursement program provided expanded funding to programs providing nutrition education to those individuals eligible for Food Stamp benefits. The Department of Human Services, which administers the Food Stamp program, contracts with HHI and the University of Hawaii's College of Tropical Agriculture and Human Resources to coordinate an integrated approach to nutrition education in schools and community health centers.

DOE implemented its new Wellness Guidelines as part of the Local Wellness Policy adopted by the Board of Education. The guidelines include standards for food sold or provided on campus, nutrition education, physical education and support for staff development. This is part of a national effort prompted by the U. S. Department of Agriculture Child Reauthorization Act. The federal mandate required all school food authorities that participate in the National Lunch Program to establish and implement wellness policies to promote healthy schools.

HHI conducts a social marketing campaign that integrates public education with programs and policy change. Public education efforts focused on both healthy nutrition (Fruits & Veggies: Good Choice!) and physical activity (Step It Up!).

WIC provides nutrition counseling and food coupons to low-income pregnant women and families with young children. The DOH primary care contracts continue to collect BMI on uninsured children above 2 years of age for early identification and referral of overweight children in the community health clinics.

The federal Safe Routes to School (SRTS) program was designed to support efforts to encourage children to safely bicycle and walk to school; in the process, reducing traffic congestion and improving the health of children. The state Department of Transportation (DOT) administers the program and collaborated with the HHI to sponsor SRTS training for school officials, community leaders and parents to generate interest in the program. However, procurement and contracting issues have limited the number of SRTS agency and community grants awarded by the DOT. Discussions continue with DOT to address these barriers.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide training and support to Department of Education school teams to implement State Wellness Guidelines that include standards for food sold or provided on campus, nutrition education, physical education and activity, and staff development.				X
2. Assure data is available on youth weight and weight related behaviors through the Youth Risk Behavior Survey.				X
3. Promote the use of the Hawaii Pediatric Weight Management Toolkit among pediatric providers.				X
4. Implement the USDA Food Stamp Nutrition Education Network program to secure additional federal funding for programs providing nutrition education to individuals eligible for Food Stamp benefits.				X
5. Support community based organizations to plan and conduct health promotion activities and projects.				X
6. Promote healthy lifestyles through public education campaigns.			X	
7. Implement the State Physical Activity and Nutrition (PAN) Plan through the statewide network of NPAC coalitions.				X
8. Support Department of Health and community efforts to modify Hawai‘i’s built environment to promote safe and enjoyable physical activity through policy development, education, providing technical assistance, and community grants.				X
9. Work with state and county transportation planning agencies to support the development of pedestrian and bicycle-friendly communities including implementing the Safe Routes to Schools program.				X
10. Provide education and support on appropriate dietary practices and physical activity through the WIC program.		X		

b. Current Activities

The DOH/DOE School Health Survey Committee will continue to work collaboratively to assess school-level health-related indicators, coordinate school surveys, and develop summary reports including the levels of physical activity, weight and nutrition data.

HHI continues their efforts to promote healthy food choices and lifelong physical activity. They continue to implement the USDA, Supplemental Nutrition Assistance Program (SNAP-Ed), with enhanced education and program activities.

HHI developed tools, training sessions, and networking opportunities for agencies and community members across the islands to increase understanding on how the physical design of the built

environment impacts opportunities for daily physical activities.

In 2009, a Safe Routes to School bill (Act 100) was passed to support DOT to effectively implement the provisions of the federal legislation. Also passed was a Complete Streets bill (Act 54) directing the DOT and county transportation agencies to adopt a complete streets policy to reasonably accommodate access and mobility for all users including pedestrians, bicyclists, disabled, the elderly and children. DOH Injury Prevention and Control program (IPCP) closely monitored the legislation and kept stakeholders apprised of these and other bills to improve street safety.

As part of the Title V Needs Assessment, child obesity was identified as a continuing state priority issue. Stakeholder input was collected from a survey conducted in 2009.

c. Plan for the Coming Year

State objectives have been set to decrease 1% point every 2 years.

The DOH/DOE School Health Survey committee will continue to monitor the nutrition and physical activity of young people and prepare for the 2009 Youth Risk Behavioral Survey (YRBS) administration.

The WIC food voucher program will be adding fresh fruits and vegetables and whole grain bread to their food package for clients beginning October 1, 2009. This is part of a national WIC initiative to create healthier options for its low-income client population.

HHI will continue efforts to promote healthy food choices and lifelong physical activity. The state and county NPACs will continue work to implement provisions of the state PAN plan. Title V staff will continue to participate in NPAC meetings. HHI will continue to support the development of community based resources through the provision of ongoing training and capacity building opportunities.

HHI will continue to partner with state/county agencies and community advocates to implement and support policy changes and programmatic activities to create healthier community design and transportation options. Work to implement the SRTS legislation and Complete Streets policy will continue.

DOT is developing a statewide pedestrian plan and will also be updating the state Bike Plan. The City & County of Honolulu (CCH) is currently updating its Master Bicycle Plan which will include bicycle accommodations for future rail transit stops. DOH will continue to partner with community advocates to work with transportation officials ensure the plans help to promote and increase safe physical activity options into community design and transportation systems. These efforts help CCH implement the 2006 city charter amendment to make Honolulu a pedestrian/bike-friendly city. Collaborative efforts by the DOH to work with DOT and CCH will continue.

The DOE in partnership with HHI will continue to implement the Wellness Guidelines that includes standards for food sold or provided on campus, nutrition education, and physical education. Policies include a prohibition on the sale of any product that lists sugar as its primary ingredient and school fundraisers can no longer include the sale of candy or cookies. Schools will select components of the guidelines to implement each year. DOE requires all components of the guidelines be in place by June 2011.

The DOH-DOE Wellness team will continue providing professional development and in-service training on implementing the multiple components of the Wellness Guidelines. Utilization of a Wellness Guideline toolkit to provide online support to the schooll wellness committees will be

encouraged.

State Performance Measure 4: *Percent of teenagers in grades 6 to 8 attending public schools who report drinking alcohol within the past 30 days.*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			12	11	11
Annual Indicator	12	12.3	12.3	14.5	14.5
Numerator					
Denominator					
Data Source					Source (numerator/denominator): Hawai‘i State. Uni
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10	10	10	10	10

Notes - 2008
The Hawai‘i Youth Behavior Risk Survey (YRBS) for Middle School is data weighted to the general population by the Centers for Disease Control and Prevention (CDC). YRBS is administered in odd-numbered years in Hawai'i's public middle and high schools. The extent of underreporting or over reporting of behaviors cannot be determined because information is self-reported. The data apply only to youth who attend Hawai'i's public schools and, therefore, are not representative of all persons in this age group.

Notes - 2007
The Hawai‘i Youth Behavior Risk Survey (YRBS) for Middle School is data weighted to the general population by the Centers for Disease Control and Prevention (CDC). YRBS is administered in odd-numbered years in Hawai'i's public middle and high schools. The extent of underreporting or over reporting of behaviors cannot be determined because information is self-reported. The data apply only to youth who attend Hawai'i's public schools and, therefore, are not representative of all persons in this age group. There will be no data for 2007 since it uses YRBS middle school data. Middle school data has not been published.

Notes - 2006
The Hawaii Youth Behavior Risk Survey (YRBS) for Middle School is data weighted to the general population by the Centers for Disease Control and Prevention (CDC). YRBS is administered in odd-numbered years in Hawai'i's public middle and high schools. The extent of underreporting or over reporting of behaviors cannot be determined because information is self-reported. The data apply only to youth who attend Hawai'i's public schools and, therefore, are not representative of all persons in this age group. Data for 2005 uses the 2003-04 Middle School YRBS data, the latest available data.

a. Last Year's Accomplishments
This measure reflects the State's MCH priority to reduce underage drinking. The 2007 Youth Risk Behavior Survey (YRBS) middle school data showed 14.5% of middle school youth had at least one drink of alcohol in the last 30 days. Alcohol continued to be the drug of choice among teens. There was a slight increase from the 2005 survey. Hawaii rates remain higher than the Healthy People 2010 objective of 11%.

In the Department of Health (DOH), the Alcohol and Drug Abuse Division (ADAD) is the lead agency for underage drinking (UD). ADAD provides funding for the Hawaii Partnerships to Prevent Underage Drinking (HPPUD) Coalition which was established to coordinate statewide efforts to address underage drinking. 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. Title V staff serves on the HPPUD providing YRBS data, information on health risks related to UD, and a focus on prevention/education efforts.

DOH's Fetal Alcohol Spectrum Disorder (FASD) coordinator joined HPPUD and presented information on the debilitating lifetime effects of FASD that may result from prenatal alcohol use.

Title V staff convenes the DOH/Department of Education (DOE) Hawaii Health Survey Committee which oversees the administration of health surveys conducted in public middle and high schools to provide UD data. The Committee assists the YRBS contractor to develop strategies to ensure an adequate survey response rate.
Title V partnered with HPPUD agencies to develop, plan and conduct a 2-day youth risk behavior conference. DOH presentations were made on FASD and youth suicide prevention efforts.

Adults continue to remain the primary alcohol source for underage youth. The Honolulu Police Department (HPD) conducts "sting" operations at smaller retail stores to stop adults from purchasing alcohol for underage drinkers. The HPD program is supported by funding from ADAD. The Honolulu Liquor Commission (LC) also has ongoing investigations conducted in nightclubs and bars. In 2008 HPD and the LC provided training to military police to develop a similar sting program for military personnel. Age verification checks were also instituted at various military facilities.

HPPUD supported a social marketing campaign targeting neighbor island youth using an innovative photo documentation process (Photo Voices) to identify community norms regarding UD.

The University of Hawaii (UH) established the Manoa Alcohol Project (MAP) to decrease the UD problem on the UH main campus. The 2 major objectives of MAP are to present accurate norms about drinking on campus and to reduce harmful consequences of over-consumption.

During the 2008-09 school year, Mothers Against Drunk Driving (MADD) trained high school students to present alcohol prevention information to elementary school aged children.

HPD continued to take the lead on advocacy efforts to pursue legislation to strengthen UD laws and support prevention programs. The ignition interlock bill, HB 981, was passed in 2008. A task force was created to study the costs and impacts of the law which requires DUI offenders to install a device on their vehicles that would prevent the engine from starting if their blood alcohol level was above the legal limit. The implementation date has been delayed to 2010.

The Hawaii National Guard, LC, the DAG, and CDFH partnered on activities including public service announcements, joint presentations at the middle and high school campuses, and Teach-Ins, which use student athletes to speak to their peers.

The second annual HPPUD Conference was held in Kailua-Kona in April 2008, to bring together the neighbor island HPPUD coalitions to discuss enforcement and prevention activities, improve communications and expand training opportunities.

The Lt. Governor's (LG) office and the National Guard provide leadership to coordinate and publicize statewide UD activities. ADAD supported 11 UD Town Hall meetings hosted by various

communities. The meetings are designed to heighten awareness of the dangers of UD and discuss steps to prevent it. Mandatory meetings on Hickam Air Force Base were funded by the Enforcement of UD Military Grant for all underage military personnel. DOH's FASD coordinator participated in the military meetings to provide information on FASD.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assure data is available on youth risk behaviors including alcohol use through the Youth Risk Behavior Survey and the Alcohol, Tobacco and Other Drugs Survey.				X
2. Develop collaborative partnerships with the statewide Hawaii Partnerships to Prevent Underage Drinking Coalition to initiate programs and advocate for policies to reduce underage drinking.			X	X
3. Support the Lt. Governor's initiatives and leadership on underage drinking.			X	X
4. Coordinate and contract for underage drinking enforcement and public awareness programs.				X
5. Conduct ongoing activities and programs to prevent underage drinking by organizations like Mother Against Drunk Driving (MADD).			X	X
6. Support the national Teach-Ins program and ongoing classroom presentations on prevention of underage drinking.			X	X
7. Educate the public on the risk factors, protective factors and evidenced based strategies to prevent and reduce underage drinking.			X	X
8. Secure technical assistance to conduct further analysis of YRBS data and other substance use school surveys.				X
9. Implement the HPPUD's Strategic Plan that addresses goals and objectives to change prevailing social norm that condon underage drinking (UD) and reduce UD rates.				X
10.				

b. Current Activities

The HPPUD released its strategic plan that emphasizes the importance of collaboration among local agencies and organizations dedicated to changing social norms to prevent and reduce UD in Hawaii. HPPUD continues to encourage partnerships across agencies and disciplines around enforcement, education, and policy development.

Ongoing HPPUD activities include: public service announcements; Teach-Ins by HPPUD's speaker's bureau; support for prevention programs to raise awareness about UD by the neighbor island HPPUDs, the military, the Liquor Commission and HPD. Education continues on the State's UD laws including the increase of penalties for UD and the social host liability law targeting parents/adults that host activities serving alcohol to minors.

The third annual HPPUD conference was held on Maui this year. The neighbor island HPPUD leadership was well represented and shared their work in reducing UD and ways to improve statewide coordination.

HPPUD is collaborating with private sponsors to host an alcohol-free teen day and dance at the State's only water park on Oahu. The event will take place in September and will serve as a data gathering effort as well as an opportunity to relay messages to discourage UD.

The neighbor island photo documentation project (Photo Voices) and the UH MAP project continue activities to reduce UD. UH students are participating in the development of campaign messages to document and change the misperception that UD is the social norm on campus.

c. Plan for the Coming Year

The State objective is to decrease by 1% the number of middle school youth who report current alcohol use in the 2009 YRBS.

The HPPUD state strategic plan seeks to change the prevailing social norm that condones underage drinking (UD) and to reduce UD rates. The coalition will conduct activities in each of the four goal areas as funding permits: 1) reduce underage drinking by enforcing underage drinking laws and regulations; 2) educate youth and adults on the serious consequences of underage drinking; 3) support communication and collaboration among agencies and organizations involved in underage drinking prevention; and 4) develop and support policies that address underage drinking.

HPPUD has been progressive in passing legislation to reduce UD in the past 5 years. State laws include increased penalties for drunk driving, prohibiting consumption of alcohol in addition to purchasing and possession of alcohol for individuals under age 21, suspension of driving privileges for persons who illegally purchase, possess or consume liquor, and a social host liability law that prohibits providing alcohol to minors. HPPUD will continue to pursue policies to reduce UD.

Year round education and public awareness activities are expected to continue. This includes poster board messages in the public buses, statewide Teach-Ins on UD to elementary schools, positive messaging, public service announcements, and the community town hall meetings.

MAP activities to reduce UD on college campus continue. The project is currently funded by a grant from Anheuser Busch. The funding will end in 2010.

The military and HPD sting operations will continue targeting small retail stores. The LC will continue to monitor the bars and nightclubs for underage drinkers.

Education efforts on FASD will continue. HHPUD will continue to include FASD information into UD presentations.

HPPUD will participate in the collection of baseline data to assess the social norms, perceptions, beliefs and activities of alcohol use by young people under the legal drinking age of 21; track enforcement activities; and coordinate UD presentations as requested by schools and the general public.

HPPUD will continue efforts to improve information sharing between the Honolulu and the neighbor islands regarding activities and training/workshop opportunities.

State Performance Measure 5: *Proportion of children aged 6 to 8 years with dental caries experience in their primary and permanent teeth.*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance			73.4	71.4	70.7

Objective					
Annual Indicator	74.5	73.6	74.4	72.1	72.4
Numerator	4477	4626	5183	4445	3674
Denominator	6010	6285	6967	6165	5075
Data Source					Data Source (numerator/denominator): Hawai‘i State
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	69.3	68.6	67.9	67.2

Notes - 2007
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. Objectives have been set to decrease 2% each year.

Notes - 2006
This is a new State Performance Measure added in for the five-year report period, FY 2006-2010.

a. Last Year's Accomplishments
This measure reflects the State's MCH priority to improve the oral health of children. The 2008 data indicates 72.4% of Hawaii's children 6-8 years have experience with dental caries. The State objective of 70.4% was not met nor was the Healthy People 2010 objective of 42%.

The data for this measure comes from the State Department of Health's Dental Health Division (DHD) who collects statewide data on the even years and a smaller sample from Oahu and Maui schools on the odd years. The objectives were set based on previous data collected by DHD in the past 6 years. Statewide, DHD remains the lead agency in children's oral health data and conducts the child oral health surveillance program that compiles statewide data on children's oral health in accordance with accepted dental epidemiology standards.

This measure was chosen through the Title V needs assessment process by stakeholders. It is also one of the Healthy People 2010 objectives: reduce the proportion of children with dental caries experience either in their primary or permanent teeth. Title V is aware that the target of 42% will take time to reach as children with completed treatment needs will be counted forward as experiencing dental caries.

The Tri-County Dental Health Task Force (Maui, Kauai & Hawai'i Island) met quarterly via VCC to share dental health projects, challenges and accomplishments. The neighbor island counties work together to determine the oral health needs on their islands and address barriers to access dental care for children.

The Health Resources and Services Administration (HRSA) convened several grantees, including Title V, to participate in a State Strategic Partnership Session in 2008. The participants identified oral health as the priority health issue for the State to address. Grantees included the DOH, Papa Ola Lokahi and the Hawaii Primary Care Association. Strategies identified were to improve public health awareness and prevention education and assurance of care. Additional stakeholders that were brought into the process included the DOH's Deputy for Health Resources Administration and Dental Health Division Chief, HRSA's Chief Dental Officer, Med-QUEST Branch Chief, a representative from the Hawaii Dental Association, and faculty from the Hawaii General Dentistry Residency Program. A draft report was made available in February 2009.

Refer to the NPM 09 narrative for last year's accomplishments addressing children's oral health.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide oral screenings, education and provide follow-up in serious cases in elementary schools.	X	X	X	X
2. Administer fluoride rinse programs in public schools.	X			
3. Collect, analyze and publish oral health data on children.				X
4. Provide funding for dental services to the under- and uninsured through community health centers.		X		
5. Provide oral health education to WIC low income pregnant women and young mothers.		X		
6. Implement provisions of the Oral Health Action Plan.				X
7. Support Neighbor Island oral health community coalitions to plan and conduct activities/programs.				X
8. Convene key stakeholders to identify and implement specific strategies to improve oral health for children.				X
9.				
10.				

b. Current Activities
DHD continues to provide dental services and surveillance of school age children statewide. Dental Certificates are being provided to dentists to issue to school aged children whenever their dental treatment is completed. Parents are encouraged to present the certificates to their child's school.

A training curriculum for fluoride varnish is also being developed for use by Early Periodic Screening Diagnosis and Treatment (EPSDT) and Medicaid providers.

Hawaii Island Oral Health Task Force is creating a dental services listing that will include information on dentists according to geographical districts served, the type of services provided, ages served and type of payment accepted. The data will be used to quantify needs and to apply for future funding.

The Hawaii Island mobile dental van program partnered with the University of Iowa Dental School to provide internship experience to a team of pediatric dentists. The dentists visited 2 public elementary schools providing education and dental services to students with Medicaid coverage or without dental insurance at no cost.

The HRSA State Strategic Partnership project on oral health released a report in February 2009. Due to the State's poor economy, work on the recommendations is postponed.

As part of the Title V Needs Assessment, children's oral health was not identified as a continuing state priority based on stakeholder input and limited capacity to address the issue.

See NPM 09 for other activities.

c. Plan for the Coming Year
Objectives have been set to decrease 2% each year.

Title V will continue to support DHD to acquire current data for this measure and other oral health indicators for children using SSDI grant funds. The data collected is essential to identify key issues and strategies to improve the oral health of children. At this time DHD has not suffered any budget restrictions.

Title V will support the recommendations of the Hawaiian Islands Oral Health Task Force and will continue its efforts to support the safety-net providers to expand their dental capabilities to provide direct services to the underinsured and uninsured.

Title V recognizes that good oral health and prevention of caries formation for children begins with pregnant women and women of childbearing age. Oral health education will continue to be included in all population-based programs for perinatal clients and advocating for dental care will continue to be included in all health insurance coverage for pregnant women. These prevention efforts and education will continue with the parents of very young children as the dental caries process is established by age two years old. Title V will collaborate with WIC, primary care health centers, and programs that serve families to provide culturally appropriate education.

Title V will explore best practice programs to improve the accessibility of dental services for children 0-5 years old and collaborate with DHD to implement the program(s) utilizing existing infrastructure resources and partnerships.

Title V recognizes the serious oral health care challenge for Hawai‘i's children and will continue to collaborate with DHD, the dental providers, pediatricians, and community programs serving young families to ensure that each child, including those with special needs, has an appropriate dental home and is accessing routine care.

Refer to the NPM 09 narrative for other plans for next year activities addressing children's oral health.

State Performance Measure 6: *The rate of women aged 15-19 years (per 1,000) with a reported case of chlamydia.*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			25	24.1	23.6
Annual Indicator	32.6	26.9	28.8	27.6	33.9
Numerator	1259	1045	1129	1073	1311
Denominator	38600	38805	39257	38820	38631
Data Source					Data Source (numerator): Hawai‘i State. Department
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	23.2	22.7	22.2	21.8	21.4

Notes - 2007
This is a new State Performance Measure added in for the 5-year reporting period, FY 2006-2010. State Performance Measure #06 is the same as Health Status Indicator #05A.

Data is for the calendar year. Data for this measure is from the Department of Health (DOH),

Communicable Disease Division, STD/AIDS Prevention Services Branch. Reported positive cases primarily reflect chlamydia infections identified during screening of asymptomatic women. 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, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

Notes - 2006
This is a new State Performance Measure added in for the 5-year reporting period, FY 2006-2010. State Performance Measure #06 is the same as Health Status Indicator #05A.

Data is for the calendar year. Data for this measure is from the Department of Health (DOH), Communicable Disease Division, STD/AIDS Prevention Services Branch. Reported positive cases primarily reflect chlamydia infections identified during screening of asymptomatic women. Population data based on U.S. Census Bureau, Population Estimates Program, SC-EST2006-AGESEX_RES: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2006. Release Date: May 17, 2007.

a. Last Year's Accomplishments
This measure reflects the State priority to reduce adolescent chlamydia. It was selected due to an increase in adolescent chlamydia rates since 1998. The 2008 provisional data indicates a chlamydia case rate of 33.9 for 15-19 year olds per 1,000 females. The objective was not met. Relative to national standards, Hawaii's rate is slightly better. In 2007 (latest available national data) the U.S. rate for 15-19 year olds was 30.0 per 1,000 compared to 27.6 for Hawaii.

Although the Hawaiʻi rate went up slightly, this may reflect collaborative efforts to increase chlamydia screening. Hawaiʻi was reported to have the highest screening rate (58.6%) among the 41 states in a Centers for Disease Control (CDC) study that analyzed data from commercial and Medicaid health plans to the Healthcare Effectiveness Data and Information Set (HEDIS) during 2000-07.

Hawaii did not meet the HP 2010 objective to reduce chlamydia infections among females age 15-24 years attending family planning clinics/ sexually transmitted disease (STD) clinics to 3.0%. The Hawaii rate for 2007 was 8.4%.

For the Department of Health (DOH), the STD Prevention Program (SPP) is the lead agency for chlamydia. The SPP provides direct services for chlamydia screening and treatment at the only STD public clinic in Honolulu, the Juvenile Detention Center, and in collaboration with community partners, participates in community screening activities. SPP provides STD services on the neighbor islands, utilizing HIV counselors and testers to provide disease intervention activities and STD screening. Statewide partner notification services are available to locate partners of clients with positive test results.

The SPP received an additional $122,000 from the Legislature for 2007-2009. Funds were used to increase STD screening. This additional State funding marked the first funding increase received by the program in 12 years.

Chlamydia screening and treatment services are on 6 major islands through SPP and the DOH Family Planning Program (FPP) agreement. FPP is part of the Title V agency. FPP contracts with community health centers, private agencies, doctors, and colleges to provide STD screening and treatment at 39 sites and 80 non-family planning clinic locations for services to medically indigent or at-risk populations. The FPP contracts for family planning and STD/HIV education offered to schools, the community, and through health agencies.

Title V oversees service contracts for the Perinatal Support Service program, Baby S.A.F.E., the Perinatal Disparities Project that provide STD preventive education and referrals.

The Hawaii TeenLine and website provided STD information for Teen Pregnancy Prevention Month to help educate teens on sexual activity and STD prevention. The SPP and FPP websites provide STD information and list healthcare providers offering free/low-cost STD services for the uninsured.

The Hawaii Youth Services Network (HYSN), a coalition of statewide organizations serving youth, held a variety of trainings for educators such as "Sex Education 101 for Educators" and "HIV 101" with approximately 50 attendees.

FPP convenes an Adolescent Chlamydia Work Group (ACW) with representatives from DOH, Department of Education (DOE), youth providers, American College of Obstetricians and Gynecologists, health insurers and the university. The 2 major goals are: increase condom use among teens and increase screening and treatment. HMSA, the State's largest health insurer made increasing chlamydia screening rates a program priority. HMSA launched a comprehensive educational program for their providers, staff and clients to improve screening rates. A provider toolkit was developed that included an office poster, patient brochure, and suggestions for taking a sexual history of teenage girls. HMSA also included STD's as a category in their annual student video competition.

The SPP developed a provider survey to assess physician needs and barriers with chlamydia screening among adolescents. The survey was sent out in 2007-08 to pediatricians, family practice physicians and OB-GYNs. Preliminary survey findings were shared with the ACW and used to develop the HMSA toolkit.

In October 2007 following the publication of the CDC STD Treatment Guidelines, SPP coordinated educational activities for over 300 physicians and health care providers including: a conference, medical grand rounds at major hospitals, and a course on Partner Management.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide chlamydia screening, treatment, and prevention education at Department of Health clinic and Juvenile Detention Facility, and through special outreach projects for high risk populations.	X			
2. Provide chlamydia screening, treatment, and prevention education through Family Planning Program contracted clinics; and assessment and referral through the Perinatal Support Services, Perinatal Disparities Project in Hawaii County, and Baby S.A.F.E.	X	X		
3. Provide chlamydia prevention education in schools and in community-based youth service programs.			X	
4. Provide teacher and agency staff training in evidence based curriculums addressing sexual health including STD knowledge and prevention skills.				X
5. Continue Regional Infertility Prevention Project activities to improve reporting and data collection, appropriate screening, timely treatment, use of optimal test technology, and quality assurance to reduce chlamydia.				X
6. Conduct epidemiological analysis of disease activities to determine and evaluate patterns of chlamydia incidence and implement appropriate programs and activities to decrease the positivity rate.				X

7. Improve partner notification and treatment by monitoring the case reports and move toward implementing expedited partner therapy.				X
8. Continue quality assurance and standards development to assure timeliness of treatment and medical management of partners of clients testing positive.				X
9. Identify and implement effective strategies to reduce adolescent Chlamydia through the Adolescent Chlamydia Work Group in partnership with key stakeholders.				X
10. Provide continuing education for healthcare providers and follow-up.				X

b. Current Activities
SPP and FFP screening and education services continue.

The FFP, SPP, and the state laboratory representatives participated in the bi-annual CDC Regional Infertility Prevention Project (IPP) to improve screening, timely client and partner treatment, and use of optimal testing. Best practices from other states are shared locally for consideration.

In October 2008 the Hawaii Adolescent Sexual Health Partnership Conference, was co-sponsored by HYSN and DOE and focused on education messages addressing sexual health in the public schools. HYSN also held sexual health trainings for approximately 150 participants.

ACW helped promote April STD Awareness Month with the launch of the Get Yourself Tested (GYT) national campaign to promote increased youth testing. The national website HIVTest.org was updated to include all SPP and FPP sites providing STD testing. GYT promotional resources were used by providers to reach higher risk populations. ACW assisted with distribution of a STD information card produced by SPP to FPP health educators and other youth service agencies.

As part of the Title V needs assessment, chlamydia was on a short-list of issues submitted by the Women/Infant population workgroup but was not selected as a final state priority due to the progress made to address the issue.

The Title V Women's Health Section coordinated development and distribution of 78,600 women's health screening guides for Women's Health Week, which included chlamydia testing recommendations.

c. Plan for the Coming Year
Provisional 2007 data will be updated. State objectives are set to decrease 2% annually.

SPP and FFP screening and education services will continue although it is unclear at this time how state budget cuts and possible employee furloughs will effect provision of services. SPP is losing a social worker position for its STD clinic. FFP state funding was reduced in FY 2009.

Title V Perinatal Support Services (PSS) and the Perinatal Disparities Project will continue to provide STD preventive education and referrals. The Baby SAFE program was eliminated as a result of funding restrictions by the 2009 Legislature. However, alternative funding is being explored. PSS funds were also cut, reducing the number of pregnant women served.

The final provider survey data is anticipated to be completed in June 2009. Survey findings will be published and shared with various health plans. Efforts will be taken to develop strategies to increase screening by working with provider networks and with the partners in the ACW.

Region IX IPP activities will continue including efforts to decrease chlamydia and gonorrhea positivity in racial/ethnic minority groups.

Partner management is an important strategy to reduce the incidence of chlamydia. Expedited Partner Therapy (EPT) as a tool in partner management of patients has been presented to the State Board of Medical Examiners (BME) in the past, but the BME declined to endorse the practice due to liability concerns and tabled the issue. Fortunately, the BME did not vote to prohibit the practice commonly used by many providers. SPP and ACW partners will approach the BME again in the future when the Board composition appears more open to the practice.

The 2009 Legislature passed a bill requiring all programs receiving State funding to provide medically accurate sexuality education. This will create opportunities to provide effective and appropriate education on sexual health.

The DOE receives CDC funding to provide HIV prevention education and conduct the Youth Risk Behavior Survey (YRBS). The DOE HIV coordinator will continue to develop strategies for sharing resources, furthering school staff professional development to provide sexual health education in the schools. The YRBS 2007 data indicates 45.8% of high school students who are sexually active did not use a condom during last sexual intercourse compared to 38.5% nationwide. In Hawaii 87% of high school students reported having been taught about AIDS/HIV in school compared to 90% of high school students nationwide.

State Performance Measure 7: *Percent of women who report smoking tobacco during pregnancy.*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			8	7.6	7.2
Annual Indicator	8.1	8.4	9.4	8.4	8.4
Numerator	1420	1440	1716	1548	1548
Denominator	17633	17233	18300	18504	18504
Data Source					Data Source (numerator/denominator): Hawaiʻi State
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6.8	6.5	6.2	5.9	5.6

Notes - 2008
Data for the year 2007 is the latest data available.

Notes - 2007
This is a new State Performance Measure added in for the 5-year reporting period, FY 2006-2010.

Data for this measure comes from the Hawaiʻi Pregnancy Risk Assessment Monitoring System (PRAMS). The Hawaiʻi State Department of Health started PRAMS in June 1999 as a pilot project. The year 2000 is the first full year of PRAMS data. Data for the year 2006 is the latest data available.

Notes - 2006
This is a new State Performance Measure added in for the 5-year reporting period, FY 2006-2010.

Data for this measure comes from the Hawaiʻi Pregnancy Risk Assessment Monitoring System (PRAMS). The Hawaiʻi State Department of Health started PRAMS in June 1999 as a pilot project. The year 2000 is the first full year of PRAMS data. Data for the year 2005 is the latest data available.

a. Last Year's Accomplishments
This measure reflects the state priority to reduce smoking during pregnancy. Smoking is the single largest known preventable risk factor for poor pregnancy outcomes. The 2007 data (latest available data) indicates 8.4% of pregnant women reported smoking during pregnancy. The State objective of 7.6% was nearly met. The Healthy People 2010 objective of 1% was not met.

PRAMS analysis on data for 2004-06 shows that 20% of women report smoking prior to pregnancy with only 9% continuing to smoke during pregnancy. However, only a third remained smoke free in the postpartum period when infants can suffer respiratory afflictions and other health problems related to second hand smoke. Maternal characteristics related to women that continue to smoke during pregnancy are: Medicaid insured; unmarried; of Samoan or Hawaiian ethnicity; reside on the Big Island; a high-school graduate or less; and, pregnant for the four or more time.

Title V continues to administer the Perinatal Support Services (PSS) and Baby Substance Abuse Free Environment (SAFE) programs that provide outreach, screening, health education, case management and care coordination for high-risk and substance-using pregnant women. The PSS and Baby SAFE providers have received smoking cessation brief intervention and advanced motivational interviewing training to support clients to make healthier behavioral choices. The programs use the Brief Intervention methods when initiating support services at community clinics and WIC locations since it helps to engage poly-substance using pregnant women to participant in the PSS and Baby SAFE programs.

The federal Healthy Start Big Island Perinatal Disparities program (BIPDP) was implemented through a purchase of service contract with a community provider. The program screens pregnant women for smoking, alcohol and drug use, domestic violence and depression to decrease the incidence of poor birth outcomes on Hawaii Island.

Title V contracts with the Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii to operate the MothersCare website and phone line to provide information on health issues and perinatal resources, including smoking cessation. HMHB also conducts Smoking Cessation Brief Intervention (BI) training and an Advanced Train-the-Trainer series statewide for perinatal providers. In 2008, 6 providers completed the BI training while 11 providers completed the instructor certification. HMHB continues to promote the state smoking Quitline among pregnant women.

Title V co-chairs a Prenatal Smoking Workgroup comprised of public and private smoking prevention and perinatal programs. In the 2008 the workgroup supported introduction of legislation requesting the Department of Human Services (DHS), the state Medicaid agency, to study the feasibility of implementing a smoking cessation benefit to Medicaid enrollees all including pregnant women. The workgroup also provided guidance on the selection of smoking questions for the 2009 PRAMS Survey to the PRAMS Steering Committee.

The WIC program screens clients for smoking during pregnancy and makes referrals for further assistance at the initial client visit. Some WIC clinic locations collaborate with PSS and Baby SAFE staff to conduct smoking cessation brief intervention screening for their clients.

Hawaii is one of the last 46 states that dedicate a portion of funding received from the 1998 Tobacco Settlement to smoking prevention. The Tobacco prevention and control programs include the statewide Quitline, an aggressive media campaign, social norm change through policy development and coalition activities, surveillance/evaluation, and a community grants program. Strong advocacy and public education have led to comprehensive tobacco control laws; increases in cigarette taxes, sales restrictions to minors, and smoke free workplaces. Reducing smoking during pregnancy and during the postpartum period are objectives in the State Tobacco Prevention Plan.

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 collect, analyze and disseminate data on tobacco use before, during and after pregnancy.				X
2. Execute and administer contracts for perinatal support services to high-risk pregnant women statewide.	X	X		X
3. Execute and administer contracts for outreach and pretreatment services to pregnant women using tobacco and other drugs.	X	X		
4. 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		
5. 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
6. Provide screening and referral for WIC low income perinatal clients who use substances including tobacco.		X		
7. Support training on smoking cessation interventions for perinatal service providers.		X		X
8. Continue needs assessment efforts through the Prenatal Smoking Workgroup to promote strategies that work in smoking cessation for women before, during and after pregnancy.				X
9. 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
10. Operate the statewide toll-free smokers Quitline.			X	X

b. Current Activities

The Title V program co-sponsored a Perinatal Summit held on the Big Island in October 2008. The Summit served as a platform to highlight state perinatal data and issues in perinatal health including substance use during pregnancy. A publication of perinatal fact sheets was developed by Title V for the Summit including a fact sheet on perinatal substance use (including smoking).

The Title V PSS, Baby SAFE, BIPDP services continue. Since 2007, all perinatal service programs report whether clients smoke as a risk behavior. The program data for PSS showed that 24% smoked during pregnancy.

Due to State budget restrictions by the 2009 State Legislature, the Baby SAFE program will be

discontinued on July 1, 2009.

The Prenatal Smoking Workgroup continued advocacy in the 2009 State Legislature for a resolution requesting the DHS to study the feasibility of implementing smoking cessation opportunities for Hawaii Quest beneficiaries. This measure was passed with certified copies sent to the DHS Director, Senate and House Human Services Committee Chairs.

HMHB continues to promote utilization of smoking cessation resources among pregnant women. HMHB distributed Quit Kits to the OB/GYN faculty and staff at the Kapiolani Medical Center for Women and Children. The Quit Kits help direct women to the Quitline for personalized service in their efforts to quit smoking. HMHB provided training to 34 people in basic smoking cessation brief intervention.

c. Plan for the Coming Year

Data for PRAMS will be updated in the next year. The objectives for this measure have been set to decrease .5% every year to assure progress in achieving the Healthy People 2010 Objective.

Title V efforts will continue to focus on reducing smoking during pregnancy but also address increasing smoking cessation in the preconception period and reduce the resumption of smoking during the post-partum period.

Extension of the PSS contract for high-risk pregnant women will be executed for another two years, but due to state fiscal restrictions some PSS providers will receive less funding to provide support services.

Title V PSS and the Big Island Perinatal Disparities (BIPDP) program providers will continue to offer tobacco cessation services to high-risk pregnant women. With the termination of the Baby SAFE program and reduced PSS funding, perinatal providers will be challenged to address the gap in services with limited resources.

Title V will develop a web-based data collection system for perinatal service providers to replace the current hard-copy client reporting forms. The improved technology will increase efficiency for data entry and invoicing for services. Access to data for analysis, program evaluation and reports will be available to providers, including the prevalence rates of smoking during pregnancy and the interconception period.

HMHB will collaborate with Title V to address various perinatal issues including smoking during pregnancy.

The Prenatal Smoking Workgroup will continue to meet and discuss opportunities to increase public awareness on the dangers of smoking in pregnancy, resources for smoking cessation among pregnant women and their families, and related legislation and policies.

WIC will continue to screen clients for tobacco use and provide appropriate referral as required.

State Performance Measure 8: *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	2004	2005	2006	2007	2008

Annual Performance Objective			4.2	4.2	4.1
Annual Indicator	6.3	4.4	6.0	6.0	6.0
Numerator	1101	755	1088	1107	1107
Denominator	17530	17249	18130	18342	18342
Data Source					Data Source (numerator/denominator): Hawai‘i State
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	4.1	4	4	3.9	3.9

Notes - 2008
Data for the year 2007 is the latest data available.

Notes - 2007
This is a new State Performance Measure added in for the 5-year reporting period, FY 2006-2010.

Data for this measure comes from the Hawai‘i Pregnancy Risk Assessment Monitoring System (PRAMS). The Hawai‘i State Department of Health started PRAMS in June 1999 as a pilot project. The year 2000 is the first full year of PRAMS data. Data for the year 2006 is the latest data available.

Notes - 2006
This is a new State Performance Measure added in for the 5-year reporting period, FY 2006-2010.

Data for this measure comes from the Hawai‘i Pregnancy Risk Assessment Monitoring System (PRAMS). The Hawai‘i State Department of Health started PRAMS in June 1999 as a pilot project. The year 2000 is the first full year of PRAMS data. Data for the year 2005 is the latest data available.

a. Last Year's Accomplishments
This measure reflects the State priority to reduce prenatal alcohol use. This measure was chosen because of the increasing research demonstrating the devastating effects of alcohol on infants and children exposed prenatally. Data comes from the Pregnancy Risk Assessment Monitoring System (PRAMS). The 2007 indicator (the latest available data) is 6.0. The state objective was not met. Hawaii did meet the Healthy People 2010 objective for alcohol use during pregnancy (6%).

Title V efforts focus on providing support services to improve maternal health during the perinatal period. Staff oversees perinatal contracts that provide support services to high-risk substance-using pregnant women statewide. The Perinatal Support Services (PSS) and the Baby Substance Abuse Free Environment (SAFE) Program provide support services for at-risk pregnant women including outreach, screening, assessment, referrals, health education, case-management and care coordination for clients. In addition, Baby SAFE clients receive pretreatment services and referral for drug intervention services.

The PSS and the Baby SAFE Program Providers received Motivational Interviewing (MI) training in September 2008 to improve their counseling skills to screen and assess pregnant women for psychosocial risks such as alcohol use.

The federal Healthy Start Big Island Perinatal Disparities program (BIPDP) offers supportive services to high-risk pregnant women on Hawaii Island. Outreach is targeted toward populations that generally do not access prenatal care services. The staff has been trained by Dr. Ira Chasnoff of the Children's Research Triangle (CRT), to screen for alcohol and other substance abuse in pregnancy using the 4P's Plus screening tool. Staff learned to assess pregnant women for alcohol and substance abuse in the past, present as well as use by a parent and partner. Information on the effects of substance use during pregnancy was also presented. In 2008, training on the 4P's Plus was extended to the Big Island prenatal care providers including perinatal staff at hospitals and community health centers.

A Fetal Alcohol Spectrum Disorder (FASD) Coordinator position was established in the Title V agency in 2007. The Coordinator is responsible for facilitating the development and implementation of a comprehensive, statewide system of care for the prevention, identification, surveillance, and treatment of FASD. In 2008 Hawaii joined the National Association of FASD State Coordinators (NAFSC), participating in the quarterly meetings. Hawaii is one of only 19 states, plus the District of Columbia and the Navajo Nation that have a person designated to be the lead in their state to prevent FASD.

The FASD office sponsored several activities including "FASD 101" workshops. These trainings occurred on the islands of Oahu, Kauai, and Maui. A total of 202 participants attended representing a diversity of public and private agencies and organizations.

The FASD Coordinator works in conjunction with an advisory Task Force which meets quarterly. The Task Force is comprised of 20 members from medical and social service programs as well as parents/guardians of youth affected by prenatal alcohol exposure. The members focus efforts on alcohol warning signage, exploring opportunities to institute early childhood screening for FASD, and a public awareness campaign for FAS International Awareness Day in September. Activities included a Proclamation ceremony with the Lt. Governor and members of the FASD Task Force (which includes the Lt. Governor's wife) and an educational display for public areas/events. FASD prevention informational booklets were created and distributed statewide.

The Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii provides prenatal care information through the MothersCare phone line and web site, including a resource list for substance abuse treatment.

The WIC program screens clients for alcohol use during pregnancy at the initial client visit using a health questionnaire and makes referrals as needed.

The Perinatal Addiction Treatment of Hawaii (PATH) program, on Oahu, provides comprehensive clinical and psychosocial support to pregnant substance using women.

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 assure access to services for high-risk pregnant women statewide.	X	X		X
3. Execute and administer contracts to provide outreach and pretreatment services to substance abusing pregnant women.		X		X
4. Provide Hawaii County Perinatal Disparities Grant services for target groups through outreach and support services during pregnancy and 2 year interconception period including	X	X		

addressing risk factors for alcohol and other substances.				
5. 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
6. Advocate for policies/programs that support treatment for drug-addicted mother.				X
7. Sponsor training for perinatal service providers on screening and motivational interviewing to effectively identify substance use and encourage clients to change behaviors.		X		X
8. Provide screening and referral for WIC low income perinatal clients who use substances.		X		
9. Develop a comprehensive system of care to prevent, identify and treat FASD as directed by the statewide FASD task force and coordinator.				X
10.				

b. Current Activities

The Title V program co-sponsored a Perinatal Summit held on the Big Island in October 2008, "Developing Strategies for Healthy Women, Pregnancy and Birth Outcomes." The Summit served as a platform to highlight state perinatal data and issues in perinatal health including substance use during pregnancy. A publication of perinatal fact sheets was developed by Title V for the Summit including a fact sheet on perinatal substance/alcohol use highlighting PRAMS data.

In December 2008, the Title V staff and the FASD Coordinator participated in a 3-day Leadership Institute conducted by Dr. Ira Chasnoff intended to help build capacity and improve systems development among perinatal partners addressing alcohol and substance use by women of childbearing ages. The training was designed to encourage community health centers on Oahu to use the 4P's Plus screening tool, replicating the success on the Big Island.

The PSS and Baby SAFE Providers received training on use of the 4P's Plus to screen pregnant women for alcohol and substance abuse. The PSS and Baby SAFE providers are considering using the 4P's Plus as a standardized screening tool.

Due to the state budget deficit, funding for the Baby SAFE program will end on June 30, 2009.

The PATH Clinic received small grants to continue their services and are anticipating federal grant funding from the CDC and the Health Resources and Services Administration.

c. Plan for the Coming Year

The 2008 PRAMS data will be updated in next year's report. Objectives were set to decrease by 0.1% point every 2 years. The slight increase in alcohol use warrants close monitoring of the data.

Extension of the PSS contract for high-risk pregnant women will be executed for another two years, but due to fiscal restrictions some PSS providers will receive less funding to provide support services. The PSS Programs will continue to screen pregnant women for substance use and will meet to discuss the adoption of the 4P's Plus as a standardized screening tool.

With the demise of Baby SAFE services, the PSS providers will need to maximize efforts to provide support services to high-risk pregnant women. Pregnant women with substance abuse issues such as alcohol use in pregnancy are usually more difficult to engage in service delivery and case management. PSS Program services will adjust and incorporate new methods and ideas to fill gaps left by program cuts.

The Healthy Mothers Healthy Babies Coalition of Hawaii will continue to offer statewide pregnancy resources including information on substance abuse treatment services through the MothersCare website and phone line.

The FASD office activities focus on several areas: exploring the possibility of establishing a multidisciplinary diagnostic team/clinic; identifying opportunities for early FASD screening; strengthening the capacity of the public educational system to work with students identified or suspected of having FASD; and to increase awareness about FASD among professionals and the general community.

The BIPDP and other local prenatal care providers will continue to screen pregnant women using the 4P's Plus.

The WIC Clinics will continue to use their health surveys to screen for substance use such as alcohol use in pregnancy and in early infancy.

State Performance Measure 9: *Degree to which the action plan that supports or facilitates the transition of children & youth with special health care needs to adult life is implemented.*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			14	18	21
Annual Indicator		7	14	19	21
Numerator		7	14	19	21
Denominator	28	28	28	28	28
Data Source					Data Source
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	23	24	24	24	25

Notes - 2007
This is a new State Performance Measure added in for the five-year report period FY2006-2010. This measure is defined and tracked by scores on a checklist of 7 activities that support or facilitate the transition of children and youth with special health care needs to adult life. Scores from 0 to 4 points are based on the degree that these activities are implemented. The checklist item #5 was updated to include youth involvement in other activities including advisory and consultant roles, since these are other ways that youth can provide input into the system of services. A copy of the checklist with scoring criteria is provided as an attachment with the measure narrative in Part IV, Section D.

Notes - 2006
This is a new State Performance Measure added in for the five-year report period FY2006-2010. This measure is defined and tracked by scores on a checklist of 7 activities that support or facilitate the transition of children & youth with special health care needs to adult life. Scores from 0 to 4 points are based on the degree that these activities are implemented. A copy of the checklist with scoring criteria is provided as an attachment with the measure narrative in Part IV, Section D.

a. Last Year's Accomplishments
The Hilopaʻa Project (Integrated Systems for CSHCN) is a collaborative project of Children with Special Health Needs Branch (CSHNB) and Family Voices, with American Academy of Pediatrics (AAP)-Hawaii Chapter and University of Hawaii (UH) Department of Pediatrics, with MCH Bureau

funding. Hilopa‘a Project developed "Rainbow Book--A Medical Home Guide to Resources for CSHCN and Their Families". It is an integrated resource guide of programs for children, youth, and young adults with special health care needs. It responds to a need in the 2005 Title V CSHCN needs assessment that identified that families want access to information and want professionals who worked with them to assist families to navigate through the system. The Rainbow Book includes programs/services for transition to adult life (including education, higher education and disability access, employment, and vocational rehabilitation). Trainings have been conducted for physicians, other health professionals of various disciplines, staff from various agencies (DOH, DHS, DOE, community programs), family members, self advocates, and others. Trainings are provided on all islands. The Rainbow Book continues to be updated as needed.

The Hilopa‘a Project also developed a Transition Planning Workbook for families of CSHCN. It includes tasks/activities, decisions, timeline and resources, and is a planning guide for families, as well as a facilitation guide for providers/programs to talk with families. Workshops were provided for families of CSHCN, Children with Special Health Needs Program (CSHNP) staff, Medicaid Waiver Supervisors, and Case Managers. Workshops support the "little transitions along the way" as it prepares families at different stages to gain knowledge to enhance decision making and empowerment, which can provide a foundation for families to help their child/youth transition to adulthood. The workbook has been distributed to other states.

A Youth Advisory Council (YAC) was convened in 2005-2006 to provide opportunities to demonstrate leadership. The YAC included youths with and without disabilities, of diverse ethnicities. Sessions included promoting advocacy and understanding the Americans with Disabilities Act. During the second year, the community agency which was contracted to facilitate the YAC could not continue due to the agency's loss of the adult with special needs facilitator. Difficulties in convening the YAC have also included geography (transportation to meetings, youth located on different islands) and coordinating meeting times/dates to accommodate schedules of youths with other school/work activities. Convening a YAC was discussed with a high school special education program, but agreement was not reached.

The Hilopa‘a Project supports the implementation of a Pediatric and Family Practice Residency Curriculum which extends teaching knowledge, skills, and attributes of the Medical Home to include integrated service system roles. Sessions included Medical Home Noon Conferences with facilitators and parent representatives responding to the pediatric residents' best practice examples; and information on transition.

Children with Special Health Needs Program (CSHNP) staff finalized the Family and Individual Plans (FIP), which was renamed from Individual Service Plan to reflect the large involvement of the family. The Transition Checklist and Transition Guidelines were also finalized and are used in conjunction with the FIP. The Worksheet, based on the Hilopa‘a Transition Planning Workbook, is both reminder and documentation of issues discussed.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop and disseminate a transition checklist or planning workbook for families, providers, and programs/agencies.				X
2. Document, in the Rainbow Book II 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
3. Provide training on “Navigating the System”, which includes transition, to families of children with special health care needs				X

age 0-3 years and to families of middle-school youth prior to age 14 years.				
4. Develop and implement a “One Stop/Transition Certification” for programs, agencies, and providers, based on the framework documented in Rainbow Book II.				X
5. Establish and facilitate a Youth Advisory Council that develops personal leadership, self-determination, community advocacy skills, and/or involve youth in advisory or consultant roles.				X
6. Provide medical home curriculum that includes transition, to be incorporated into training for pediatric and family physician residents.				X
7. 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
8. CSHNP will revise the Individual Service Plan (ISP) template to include Transition Planning (TP), incorporate TP into policy and procedures, & provide staff training on the ISP, revise policy/procedures, & transition planning with clients/families.		X		X
9.				
10.				

b. Current Activities

Hilopa‘a Project/Family Voices State Coordinator continues transition trainings for families and professional partners using the Transition Planning Workbook. The workbook is on CSHNB and Hilopa‘a Family to Family Health Information Center (F2FHIC) websites. Training was provided to Developmental Disability Division supervisors and case managers in using the Workbook and Personal Health Record. A youth with special health care needs completed the youth version of the Transition Planning Workbook, and is now being formatted.

Transition was a topic at the AAP-Hawaii Chapter's conference "Pediatrics Island Style: The Adolescent Visit" in October 2008. The Family Voices State Coordinator, with an internist, presented the challenges of transitioning youth to adult medicine, local resources, and tools including a new Transition Plan Checklist.

CSHNB has updated the Rainbow Book, including new resources related to transition. The Family Voices State Coordinator will continue to provide Rainbow Book trainings.

CSHNP has incorporated the FIP and Transition Checklist into all newly admitted charts. Staff training related to transition is ongoing. The Family Handbook includes a section on transition planning, has been completed, and is awaiting approval for distribution.

In April 2009, as part of the Title V Needs Assessment, CSHNB conducted a statewide survey of 535 health care providers, advocates, and families to identify the biggest challenges for CSHCN in Hawaii.

c. Plan for the Coming Year

Although the Hilopa‘a Project ended in April 2009, CSHNB will continue to work with the Family Voices State Coordinator on updating and producing the Rainbow Book and Transition Planning Workbook, and will support as possible the trainings conducted by Family Voices/Hilopa‘a F2FHIC.

CSHNP's handbook is close to completion, and has a section explaining transition planning. Guidelines for transition planning were developed, and policy will need to be revised.

In April 2009, as part of the Title V Needs Assessment, CSHNB conducted a statewide survey of 535 health care providers, advocates, and families with CSHCN to identify the biggest challenges for CSHCN in Hawaii. Of the respondents, 25.6% of respondents identified transition to adult health care as one of the biggest challenges, 14.8% identified transition to higher education, and 12.3% identified transition to employment. A CSHCN workgroup is now focusing on the topic of transition to adult health care. This workgroup will analyze the issue and later address strategies for improvement. A FHSD meeting in November 2009 will involve stakeholders in this process.

Family social situations are increasingly complex and requests have an urgency not seen before in these numbers. CSHNP must collaborate extensively to best utilize available services to meet family need. Greater outreach efforts and communication with community partners can improve coordination and service delivery.

E. Health Status Indicators

Introduction

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 data is reported on forms 20 and 21.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	9.5	8.2	8.0	7.9	8.1
Numerator	1731	1464	1521	1515	1567
Denominator	18242	17882	18927	19086	19408
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

Notes - 2007

Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated birth data file. Data for the year 2007 is based on a provisional birth data file.

Notes - 2006

Data is for resident population and is by calendar year. Data for the year 2005 was revised with an updated birth data file. Data for the year 2006 is based on a provisional birth data file.

Narrative:

Low birth weight (LBW) 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.

The steadily increasing percentage of LBW births since 2000 in Hawaii is a very concerning trend. About, 8.2% of births in Hawaii in 2005 were considered to be of LBW, which is slightly above the national proportion of 8.1% in 2004. The percentage in Hawaii has varied over the past 6 years, from a low of 7.4% (2000) to a high of 8.6% (2003). Hawaii remains above the Healthy People 2010 objective of 5.0% of all live births to be LBW.

/2008/ In 2006, 8.0% (provisional) of all births were determined to of LBW. This is similar to recent years, and remains in excess of the Healthy People 2010 objective. The 2004 proportion was updated to 7.8%. //2008//
/2009/ In 2007, stable rate, 8.0%//2009//
/2010/ Update 2007 rate to 7.9%, the 2008 rate is similar to previous year at 8.1%. For updates on program efforts to improve perinatal health see narratives for NPM 15-19 and SPM 7 and 8. //2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.3	6.8	6.7	6.6	6.5
Numerator	1119	1177	1234	1217	1218
Denominator	17715	17376	18368	18563	18812
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

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated birth data file. Data for the year 2007 is based on a provisional birth data file.

Notes - 2006
Data is for resident population and is by calendar year. Data for the year 2005 was revised with an updated birth data file. Data for the year 2006 is based on a provisional birth data file.

Narrative:
The percentage of infants born in a singleton pregnancy has remained fairly stable in Hawaii since 2000 and ranged from 6.3% (2000 and 2004) to 7.2% (2003).The percentage in 2005 was 6.8% in Hawaii, compared to the national percentage of 6.2% in 2003. This elevation in Hawaii could be due to many factors including the race/ethnic diversity in Hawaii. 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.

/2008/ In 2006, 6.7% (provisional) of all singleton births were LBW. This is similar to recent years. //2008//
/2009/In 2007, stable rate, 6.6%//2009//

/2010/ In 2008, the rate is similar to previous year at 6.5%. For updates on program efforts to improve perinatal health see narratives for NPM 15-19 and SPM 7 and 8. //2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.3	1.4	1.3	1.2	1.2
Numerator	238	242	252	229	235
Denominator	18242	17882	18927	19086	19408
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

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated birth data file. Data for the year 2007 is based on a provisional birth data file.

Notes - 2006
Data is for resident population and is by calendar year. Data for the year 2005 was revised with an updated birth data file. Data for the year 2006 is based on a provisional birth data file.

Narrative:
The percentage of very low birth weight (VLBW) births has been shown to be more directly related to infant morbidity and mortality than low birth weight and is also highly influenced by multiple gestation pregnancies. The overall VLBW percentage in Hawaii in 2005 is estimated to be 1.4% (provisional data) and has remained stable in all births over the last six years ranging from a low of 1.2% (2000 and 2001) to a high of 1.5% (2002). Hawaii exceeds the Healthy People 2010 objective of 0.9% but is less than the national proportion of 1.5% found in 2004. Current programs like statewide perinatal support services that target high risk women and general women's health promotion programs described in this report must continue to impact this number by promoting interventions that decrease the risks of very low birth weight in those groups who are particularly at risk. This indicator must be carefully monitored to see if the current trends continue.

/2008/ In 2006, 1.3% (provisional) of all births were determined to of VLBW. This is similar to recent years, and remains in excess of the Healthy People 2010 objective. //2008//
/2009/in 2007, stable rate, 1.2%//2009//
//2010/ In 2008, the rate similar to previous year at 1.2%. For updates on program efforts to improve perinatal health see narratives for NPM 15-19 and SPM 7 and 8. //2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.0	1.0	1.1	0.9	1.0
Numerator	181	182	195	170	182

Denominator	17715	17376	18368	18563	18812
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

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated birth data file. Data for the year 2007 is based on a provisional birth data file.

Notes - 2006
Data is for resident population and is by calendar year. Data for the year 2004 was revised with an updated birth data file. Data for the year 2005 is based on a provisional birth data file.

Narrative:
The proportion of VLBW among singleton births in Hawaii was 1.0% in 2005 and this indicator has remained stable over the last 6 years, a low of 1.0% (2000, 2001, 2004, and 2005) and a high of 1.2% (2003). Current programs like statewide perinatal support services that target high risk women and general women's health promotion programs described in this report continue and strive to impact this number by promoting programs that decrease the risks of very low birth weight in those groups who are particularly at risk. This indicator must be carefully monitored to see if the current trends continue.

/2008/ In 2006, 1.1% (provisional) of all singleton births were VLBW and similar to recent years. //2008//
/2009/In 2007, some decrease in rate 0.9%//2009//
/2010/ In 2008, the rate similar to previous year at 1.0%. For updates on program efforts to improve perinatal health see narratives for NPM 15-19 and SPM 7 and 8. //2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	5.6	6.0	5.5	7.6	6.3
Numerator	14	14	13	18	15
Denominator	248365	234919	237934	237309	236932
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.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

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 data of the reported data.

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated death data file. Data for the year 2007 is based on a provisional death 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, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

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 data of the reported data.

Notes - 2006
Data is for resident population and is by calendar year. Data for the year 2005 was revised with an updated death data file. Data for the year 2006 is based on a provisional death data file. Population data based on U.S. Census Bureau, Population Estimates Program, SC-EST2006-AGESEX_RES: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2006. Release Date: May 17, 2007.

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 data of the reported data.

Narrative:
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. The death rate in children 14 years and under due to unintentional injury has decreased somewhat to a rate of 5.5 per 100,000 children 14 years and younger, which is encouraging and further reduction in the rate will be important to follow. This indicator has varied from 4.5 (2001) to 7.3 (2002 and 2003).

Infrastructure building efforts have been key to reducing the death 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. These types of services have likely contributed to the low rate.
/2008/ The number and death rate due to unintentional injuries in Hawaii in children under 15 years of age declined somewhat with 14 corresponding to a rate of 5.6 per 100,000 children (updated from previous report) in 2005 to 113 deaths with a corresponding rate of 5.3 (provisional) per 100,000 in 2006.//2008//

/2009/ In 2007, the rate increased to 7.6 per 100,000 from 5.6 and 5.3 in 2005, 2006 respectively. Continued surveillance and prevention activities will monitor this indicator. //2009//

/2010/ In 2008, the rate similar to previous year at 6.3 per 100,000. For updates on program efforts to reduce child motor vehicle related deaths see the NPM 10 narrative. //2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.9	2.0	2.0	2.7	2.5
Numerator	14	14	14	19	18
Denominator	745237	710096	706304	715232	712175
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.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
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 data of the reported data.

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated death data file. Data for the year 2007 is based on a provisional death data file. Calculation based on 3-year moving average. 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, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

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 data of the reported data.

Notes - 2006
Data is for resident population and is by calendar year. Data for the year 2005 was revised with an updated death data file. Data for the year 2006 is based on a provisional death data file. Calculation based on 3-year moving average. Population data based on U.S. Census Bureau, Population Estimates Program, SC-EST2006-AGESEX_RES: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2006. Release Date: May 17, 2007.

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 data of the reported data.

Narrative:
The death rate in children 14 years and under due to motor vehicle decreased slightly with a rate of 1.9 per 100,000 in 2004. This rate has remained consistent in Hawaii over the past 6 years and has ranged from 1.4 (2000) to 2.2 (2002 and 2003).The Healthy People 2010 objective (15-15a) for this is to reduce deaths caused by motor vehicle accidents to 9.0 deaths per 100,000 in the general population (4.2 per 100,000 was the national baseline for those 0-14 years of age in 1998). In this age group, Hawaii is doing well and this is likely due to programs described in the narrative for HSI 3A. The continuation of these programs and development of others may help further decrease these unintentional injuries.

/2008/ The number of deaths due to unintentional injuries due to motor vehicle crashes in Hawaii in children under 15 years of age increased to 7 in 2006. The 3 year moving average calculation has remained 1.9 (provisional) per 100,000 children aged 14 years and younger in 2005. The 3 year moving average has not been calculated for the time period 2004-2006 at the time of report submission. //2008//
/2009/The rate for 2004-2006 was calculated as 2.7 the rate for 2005-2007 not available at timing of submission//2009//

/2010/The rate for 2005-2007 was calculated as 2.5 as the rate for 2006-2008 not available at timing of submission. For updates on program efforts to reduce child motor vehicle related deaths see the NPM 10 narrative. //2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	18.5	16.1	16.9	17.3	10.4
Numerator	32	28	30	30	18
Denominator	172551	174278	177157	173876	173145
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

Notes - 2008
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 data of the reported data.

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated death data file. Data for the year 2007 is based on a provisional death 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, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

Notes - 2006
Data is for resident population and is by calendar year. Data for the year 2005 was revised with an updated death data file. Data for the year 2006 is based on a provisional death data file. Population data based on U.S. Census Bureau, Population Estimates Program, SC-EST2006-AGESEX_RES: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2006. Release Date: May 17, 2007.

Narrative:
In adolescents and young adults, aged 15-24 years, the death rate due to motor vehicle crashes is 15.5 per 100,000 which is down somewhat from 2004, and has ranged from 15.5 (2001 and 2005) to 28.3 (2003). The Healthy People 2010 objective (15-15a) for this is to reduce deaths caused by motor vehicle accidents to 9.0 deaths per 100,000 people in the population (25.4 per 100,000 was baseline for those 15-24 years of age in 1998). Hawaii's lower rate is likely due to

programs described in SPM 4 on underage drinking.

/2008/ The number of deaths due to unintentional injuries due to motor vehicle crashes in Hawaii in children aged 15 to 24 years increased somewhat to 30 in 2006, corresponding to a rate of 17.0 (provisional) deaths per 100,000 youths aged 15-24 years in Hawaii. The rate in 2005 was updated to 16.1 with an updated death data file. //2008//
/2009/ In 2007, the indicator was 16.7. The 2006 indicator updated to 16.9 //2009//
/2010/ The 2007 indicator was updated to 17.3. In 2008, the indicator decrease to 10.4 per 100,000 and will be monitored through continued surveillance and prevention activities. For updates on program efforts to motor vehicle related deaths for adolescents and young adults see the SPM 4 narrative on underage drinking. //2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	245.2	262.2	235.8	236.8	225.0
Numerator	609	616	561	562	533
Denominator	248365	234919	237934	237309	236932
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

Notes - 2007
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, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

Notes - 2006
Population data based on U.S. Census Bureau, Population Estimates Program, SC-EST2006-AGESEX_RES: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2006. Release Date: May 17, 2007.

Narrative:
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. The number of nonfatal injuries in Hawaii continues to decline somewhat with a total of 617, representing a rate of 244.1 per 100,000 children 14 years and younger, in 2005. Programs addressing child injury described in this report (NPM 10) have likely contributed to the rate in Hawaii.

/2008/The number and rate of nonfatal injuries in Hawaii continues to decline with 616 corresponding to a rate of 248.4 per 100,000 children (updated from previous report) in 2005 to 561 injuries with a corresponding rate of 227.4 (provisional) per 100,000 in 2006.//2008//
/2009/In 2007, rate was 238.6. The rate for 2006 updated to 240.3//2009//

/2010/ The rate for 2008 was similar to previous year at 225.0. The indicator was updated in

2007 to a rate of 236.8. For updates on program efforts to reduce child motor vehicle related deaths and injuries see the narrative for NPM 10.//2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	45.9	46.0	41.6	40.0	29.1
Numerator	114	108	99	95	69
Denominator	248365	234919	237934	237309	236932
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

Notes - 2007
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, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

Notes - 2006
Population data based on U.S. Census Bureau, Population Estimates Program, SC-EST2006-AGESEX_RES: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2006. Release Date: May 17, 2007.

Narrative:
Injuries due to motor vehicles continues to increase in Hawaii with 127 injuries, representing a rate of 50.2 per 100,000 children 14 years and younger, in 2005. Unlike fatal injuries, the highest rates of hospitalizations and emergency department visits for non-fatal injuries in pedestrian crashes were computed for children under age 15 year of age. Although 1/3rd of pedestrian injuries were under 15, only 7% of those were killed suggesting children tend to survive pedestrian crashes better than other age groups.

KIPC, IPCP, and the State Department of Transportation have been actively pursuing policies and programs to make Hawai‘i's streets safer for pedestrians given the increasing number of highly publicized pedestrian and traffic fatalities over the past few years. The 2005 State Injury Prevention plan targets motor vehicle occupant and pedestrian specific injuries as important priorities to address over the next 5 years.

/2008/The number and rate of nonfatal injuries due to motor vehicle crashes in Hawaii continues to decline with 108 corresponding to a rate of 43.6 per 100,000 children under 15 years of age (updated from previous report) in 2005 to 94 injuries with a corresponding rate of 38.1 (provisional) per 100,000 children under 15 years of age in 2006.//2008//
/2009/In 2007, the rate for the 95 injuries was 40.3. The rate for 2006 updated to 42.4 and 99 injuries//2009//

/2010/ The rate for 2008 was somewhat smaller than the previous year at 29.1, but the significance of this decline is unclear and will be continued to be monitored. The indicator was updated in 2007 to a rate of 40.0. For updates on program efforts to reduce child

motor vehicle related deaths and injuries see the narrative for NPM 10. //2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	217.9	219.8	188.4	161.6	145.0
Numerator	376	383	334	281	251
Denominator	172551	174278	177257	173876	173145
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

Notes - 2007
Data is for resident population and is by calendar year. 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, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

Notes - 2006
Data is for resident population and is by calendar year. Data for the year 2005 was revised with an updated death data file. Data for the year 2006 is based on a provisional death data file. Population data based on U.S. Census Bureau, Population Estimates Program, SC-EST2006-AGESEX_RES: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2006. Release Date: May 17, 2007.

Narrative:
The number and rate of non-injuries due to motor vehicle crashes among youth aged 15 to 24 continues to increase, with 382 nonfatal injuries in 2005, representing a rate of 211.1 per 100,000 children aged 15 to 24 years. There is no specific Healthy People 2010 objective by age group for this indicator other than the related objective (15-17) which is to reduce nonfatal injuries caused by motor vehicle crashes to 1,000 nonfatal injuries per 100,000 in the general population. (3,116 per 100,000 for those 16-20 years of age and 2,496 per 100,000 for those 21-24 years of age were the baselines in 1998).

Population based and infrastructure building services described in the narrative for SPM 4 on underage drinking have likely contributed to the significantly low rate in Hawaii. It is important to monitor the recent trends and develop programs to further lower the rate.

/2008/The number and rate of nonfatal injuries due to motor vehicle crashes in Hawaii among those aged 15 to 24 years continues to decline with 383 injuries corresponding to a rate of 219.8 per 100,000 children 15 to 24 years of age (updated from previous report) in 2005 to 334 injuries with a corresponding rate of 189.3 (provisional) per 100,000 children 15 to 24 years of age in 2006.//2008//
/2009/In 2007, the rate for the 281 reported injuries was 161.9. The 2006 data was updated to 344 injuries and a rate of 194.2 //2009//
/2010/ In 2008, the rate for the 251 reported injuries was 145.0 and similar to the previous

year. The 2007 data was updated to a rate of 161.6. For updates on program efforts to motor vehicle related deaths for adolescents and young adults see the SPM 4 narrative on underage drinking. //2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	32.5	26.9	28.9	27.6	33.9
Numerator	1256	1045	1129	1073	1311
Denominator	38600	38805	39020	38820	38631
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

Notes - 2007
Health Status Indicator #05A is the same as State Performance Measure #06. 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, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

Notes - 2006
Health Status Indicator #05A is the same as State Performance Measure #06. Population data based on U.S. Census Bureau, Population Estimates Program, SC-EST2006-AGESEX_RES: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2006. Release Date: May 17, 2007.

Narrative:
Chlamydia can impact reproductive health and is among the most frequently reported communicable disease in the US. High rates are found in sexually active adolescents and young adults, particularly in those 15-19 years of age. In Hawaii, the number and rate of reported cases of Chlamydia among women aged 15 to 19 decreased slightly with 1,045 cases, representing a rate of 25.1 per 1,000 women aged 15-19 years, in 2005. This indicator has varied from 21.8 (2000) to 30.7 (2004) in Hawaii over the past 6 years.

The related Healthy People 2010 objective (25-1) for this is to reduce the proportion of adolescents and young adults with Chlamydia trachomatis infections with the objectives 25-1a (reduce the proportion of females aged 15-24 attending family planning clinics to 3.0%, baseline 5.0% in 1997) and 25-1b (reduce the proportion of females 15-24 years attending STD clinics to 3.0%, baseline 12.0% in 1997). The higher rates recently may be due to an increased knowledge and screening efforts in the general population, but should be further evaluated. Programs designed to reduce Chlamydia for this age group are described in SPM 6.

/2008/ The number and rate of reported cases of Chlamydia in Hawaii among women aged 15 to 19 years continues to decline with 1045 cases corresponding to a rate of 26.5 per 1,000 women 15 to 19 years of age (updated from previous report) in 2005 and was similar with 1,129 cases reflecting a corresponding rate of 28.3 (provisional) per 1,000 women 15 to 19 years of age in

2006. //2008//
/2009/In 2007, the number of cases decreased to 1073 with a rate of 27.5. The rate in 2006 was updated to 28.8//2009//
/2010/ In 2008, the number of cases increased to 1311 with a corresponding rate of 33.9, and the significance of this change is uncertain and will be continued to be monitored. The rate in 2007 was updated to 27.6. For updates on efforts to reduce chlamydia see SPM 6. //2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	17.7	13.5	13.7	14.4	14.3
Numerator	3823	2905	2909	3027	2997
Denominator	216386	215645	212814	210671	210227
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

Notes - 2007
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, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

Notes - 2006
Population data based on U.S. Census Bureau, Population Estimates Program, SC-EST2006-AGESEX_RES: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2006. Release Date: May 17, 2007.

Narrative:
The burden of Chlamydia among adult women in Hawaii has followed a similar course with 2,905 reported cases, representing a rate of 13.7 per 1,000 women aged 20-44 years, in 2005. This indicator has varied from 8.4 (2000) to 18.0 (2004) in Hawaii over the past 6 years. The related Healthy People 2010 objective (25-18) for this is to increase the proportion of primary care providers who treat patients with sexually transmitted diseases and who manage cases according to recognized standards. Other related objectives are 25-1a (reduce the proportion of females aged 15-24 attending family planning clinics to 3.0%, baseline 5.0% in 1997) and 25-1b (reduce the proportion of females 15-24 years attending STD clinics to 3.0%, baseline 12.0% in 1997).

The higher rates recently may be due to an increased knowledge in the general population and improved screening methods and programs, but should be further evaluated. Programs designed to reduce the impact in those with disease and the prevention of infection in those without the disease through population based measures educational/media campaigns will help continue to positively impact this indicator.

/2008/ The number and rate of reported cases of Chlamydia in Hawaii among women aged 20 to 44 years continues to decline with 2,905 cases corresponding to a rate of 13.4 per 1,000 women

20 to 44 years of age (updated from previous report) in 2005 and was similar with 2,909 cases reflecting a corresponding rate of 13.4 (provisional) per 1,000 women 20 to 44 years of age in 2006.//2008//
/2009/In 2007, 3,027 cases reflecting a rate of 14.2 were reported. The rate for 2006 was updated to 13.5//2009//
/2010/ In 2008, 2,997 cases reflecting a rate of 14.3 were reported. The rate for 2007 was updated to 14.4. For updates on efforts to reduce chlamydia see SPM 6. //2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	18472	4661	753	133	4343	1552	7030	0
Children 1 through 4	70735	19009	3151	593	18304	7393	22285	0
Children 5 through 9	75483	19975	4000	787	20873	8936	20912	0
Children 10 through 14	74242	17159	3347	394	21498	8700	23144	0
Children 15 through 19	81358	18321	2854	445	24708	9837	25193	0
Children 20 through 24	91787	32104	4758	700	23213	9181	21831	0
Children 0 through 24	412077	111229	18863	3052	112939	45599	120395	0

Notes - 2010

Narrative:
Demographically, Hawaii is diverse and very multi-cultural and this is reflected in its' children between the ages of 0 and 24. A high proportion of children are of Asian (38.5%) and Native Hawaiian or other Pacific Islander (37.6%), with smaller proportions being White (15.7%) or Black (2.5%).

/2008/ Data from the 2006 survey is not available at the time of this report. //2008//
/2009/Survey results not available due to weighting issues. //2009//

/2010/ Reporting of race in Hawaii has changed with this application. In 2005, data from the Office of Health Status Monitoring survey of households was used. Data from this source continues to not be available so a transition occurred with reporting now being based on the US Census Bureau Population Estimates. The method of data collection and race categorization differs from that used previously including the reporting of a multiple race category.

This is reflected in that 25.2% of children aged 0-24 report more than 1 race, while a single Asian category occurs in 27.4% of children, 27.0% of children are considered white, while Native Hawaiian or Other Pacific Islander (NHOPI) children occur in 11.1%. Similar patterns are seen within each age group. Further details are listed in the table and accompanying

data notes. //2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	15477	2995	0
Children 1 through 4	56264	12471	0
Children 5 through 9	63011	12472	0
Children 10 through 14	65294	8948	0
Children 15 through 19	72334	9024	0
Children 20 through 24	81207	10580	0
Children 0 through 24	353587	56490	0

Notes - 2010

Narrative:
Hispanic or Latino ethnicity was reported in a small proportion (4%) and was not recorded in <1% of all children 0 to 24 years of age.

/2008/ Data from the 2006 survey is not available at the time of this report. //2008//
/2009/Survey results not available due to weighting issues. //2009//

/2010/ Reporting of ethnicity for Hawaii has changed with this application. In 2005, data from the Office of Health Status Monitoring survey of households was used. Data from this source continues to not be available so a transition occurred with reporting now being based on the US Census Bureau Population Estimates. The method of data collection and ethnicity categorization differs from that used previously.

For Hispanic/Latino ethnicity, 58,490 individuals did not report on ethnicity. Overall 16% of children report a Hispanic/Latino ethnicity. The relative large proportion is unclear at this time and changes from prior data likely reflects a change in data collection rather than a large influx of Hispanic/Latino children. //2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	15	0	0	0	3	12	0	0
Women 15 through 17	432	24	5	6	96	288	0	13
Women 18	1190	120	24	20	247	750	0	29

through 19								
Women 20 through 34	14353	3395	404	204	4720	5380	0	250
Women 35 or older	3417	746	46	39	1801	735	0	50
Women of all ages	19407	4285	479	269	6867	7165	0	342

Notes - 2010

Narrative:
The demographics of women in Hawaii with a live birth is diverse. A high proportion of women are Asian (37.3%) and Native Hawaiian or other Pacific Islander (37.1%), with smaller proportions being white (19.7%) or black (2.3%). There was significant variation by age, with 74.0% births occurring to women between the ages of 20 and 34 years of age and 2.7% of births were in women under 18 years of age and a total of 16 births were to women under the age of 15. There was substantial variation by race and age groups, with native Hawaiians or Other Pacific Islanders having 13 of the 16 births to women under the age of 15, 70.6% of births in women 15 to 17 years of age, and 59.4% of births in women 18 to19 years of age. In comparisons, Asians had the largest proportion of births (53.2%) in those women 35 years and older.

/2008/ Data from the 2006 survey is based on the provisional birth data file and similar to previous year. //2008//
/2009/ Data based on the 2007 provisional birth file and similar to previous year. //2009//

/2010/ In 2008 births, 35.4% were to mothers who were Asian, 36.9% were to mothers of Native Hawaiian or Other Pacific Islander (NHOPI) race, and 22.1% were to mothers who were White. There was significant variation by age, with 74.0% births occurring to women between the ages of 20 and 34 years of age and 2.3% of births were in women under 18 years of age with a total of 15 births to women under the age of 15. NHOPI women had 12 of the 15 births in those under the age of 15, 67% of the births to women 15-17 years of age, and 63% of births in those 18-19 years of age. Births to mothers who were 35 years and older were most common in Asian women (52.7%), while NHOPI (21.5%) and White (21.8%) women had similar proportions of births.

This measure does not reflect the large percentage of Hawaii residents that identify with more than one race. This data is from Office of Health Status Monitoring based on birth certificate data for which race has been coded to a single race group, and thus does not reflect the multicultural nature in Hawaii. A recent study by the National Centers for Health Statistics showed that a 33.4% of mothers who had a live birth in 2003 and 32.4% of fathers should be considered to be of multiple race based on the five federally designated groups (White, Black, American Indian/Alaskan Native, Asian, and NHOPI). //2010//

Programs that target young Native Hawaiian or Other Pacific Islanders women and their partners should be an important focus for public health programs. Programs that ensure adequate screening for increased risk in pregnancy in Asian mothers is important.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY	Total NOT Hispanic or	Total Hispanic or	Ethnicity Not

Total live births	**Latino**	**Latino**	**Reported**
Women < 15	13	2	2
Women 15 through 17	313	112	7
Women 18 through 19	906	281	3
Women 20 through 34	11970	2353	30
Women 35 or older	3092	317	8
Women of all ages	16294	3065	50

Notes - 2010

Narrative:
Hispanic or Latino ethnicity was reported in 15.7% of live births, and was not recorded in <0.3% of all women who had a live birth in 2005. There was some variation in the proportion of births by age for each ethnicity. In non Hispanic or Latino, 2.3% of births were in those under 18 years of age, 4.9% in those 18 to 19 years of age, 73.4% of births in those between the ages of 20 and 34, and 19.1% of births in women 35 years and older. This compares to those that reported being of Hispanic or Latino ethnicity which had 5.0% under 18 years of age, 9.8% were 18 to 19 years of age, 75.6% were 20-34 years of age, and 9.5% were over 35 years of age. Those that identified themselves as Hispanic or Latino were generally younger.

/2008/ Data from the 2006 survey is based on the provisional birth data file and similar to previous year. //2008//
/2009/Data based on the 2007 provisional birth file and similar to previous year. //2009//

/2010/. Overall, a Hispanic/Latino ethnicity for the mother occurred in 15.8% of births in 2008, and was not recorded in <0.3% of women who had a live birth. This estimate is similar to previously reported data. There was some variation in the proportion of births by age for each ethnicity. Within all Hispanic/Latino maternal ethnicity births in 2008, 3.7% were in those under 18 years of age, 9.2% in those 18 to 19 years of age, 76.7% in those between the ages of 20 and 34, and 10.3% of births in women 35 years and older. This compares to those that did not report being of Hispanic/Latino ethnicity which had 2.0% under 18 years of age, 5.6% were 18 to 19 years of age, 73.5% were 20-34 years of age, and 19.0% were over 35 years of age. //2010//

Programs that target young Hispanic women and their partners should be an important focus for public health programs.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	102	11	5	0	28	57	0	1
Children 1 through 4	15	0	0	0	3	10	0	2
Children 5	9	1	1	0	3	3	0	1

through 9								
Children 10 through 14	8	1	0	0	2	5	0	0
Children 15 through 19	37	6	0	0	8	22	0	1
Children 20 through 24	43	13	2	0	13	13	0	2
Children 0 through 24	214	32	8	0	57	110	0	7

Notes - 2010

Narrative:
The demographic differences between the resident population and child deaths from 0 to 24 years of age should help identify particular groups at increased risk. There was some variation by age, with the majority of child deaths (53.1%) in children under the age of 5. The greatest number and proportions occurred in infants under 1 year of age (46.9%). Additional variation was found by race where a high percentage of child deaths were in Native Hawaiian or Other Pacific Islander (54.8% vs. 36.4% [2004] of children in Hawaii) and Asian (26.1% vs. 39.5% [2004]) children, with smaller variance among Whites (14.5% vs. 14.7% [2004]) and Blacks (3.3% vs. 3.0% [2004]).

/2008/There was some variation by age, with the majority of child deaths (n=259) occurring in children under the age of 5 and similar to previous year.//2008//
/2009/ 45.5% of the 255 deaths occurred to children under the age of 1 year. There were similar patterns seen with the race groups identified with previous data //2009//

/2010/ In 2008, there was a decrease in the number of deaths (214) in children compared to the previous year (255). By age group, 47.7% of the 214 deaths occurred to children under the age of 1 year in a similar proportion to that previously reported. 51.4% of all children deaths occurred to children who were Native Hawaiian or Other Pacific Islander (NHOPI), 26.7% were to Asian children, and 15.0% were to White children. There were similar patterns seen with the race groups identified with previous data.

This measure does not reflect the large percentage of Hawaii residents that identify with more than one race. This data is from Office of Health Status Monitoring based on birth certificate data for which race has been coded to a single race group, and thus does not reflect the multicultural nature in Hawaii. A recent study by the National Centers for Health Statistics showed that a 33.4% of mothers who had a live birth in 2003 and 32.4% of fathers should be considered to be of multiple race based on the five federally designated groups (White, Black, American Indian/Alaskan Native, Asian, and NHOPI). //2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	85	15	2
Children 1 through 4	11	4	0
Children 5 through 9	6	3	0
Children 10 through	8	0	0

14			
Children 15 through 19	35	2	0
Children 20 through 24	40	3	0
Children 0 through 24	185	27	2

Notes - 2010

Narrative:
Hispanic or Latino ethnicity was reported in a large percentage of deaths (20.7% vs. 3.1% [2004] of children that were Hispanic or Latino) and ethnicity was not recorded in <0.4% of all deaths to children of 0 to 24 years of age in 2005. There was some variation in ethnicity by age of death. In the non Hispanic or Latino child deaths, 42.0% were to infants under the age of 1, 48.9% of the deaths were to children under the age of 5, and 27.4% of the deaths were to children between the ages of 20 and 24. This compares to the Hispanic or Latino child deaths, 64.0% were to infants under the age of 1, 68.0% of the deaths were to children under the age of 5, and 20.0% of the deaths were to children between the ages of 20 and 24.

/2008/There was some variation by ethnicity and similar to previous year.//2008//
/2009/15.3% of all deaths reported Hispanic or Latino ethnicity similar to the 15.9% of births reporting Hispanic or Latino ethnicity. Similar variation by age previously reported. //2009//

Note that this measure does not reflect the large percentage of Hawaii residents that identify with more than 1 race.

/2008/Native Hawaiian or Other Pacific Islander and Hispanic or Latinos are over-represented in child deaths, findings that were reported in the 1997-2000 Child Death Review report. Discussions with community partners and other stake holders to address ethnic disparities in child mortality and continued surveillance of race and ethnic changes in the population are important in monitoring the health of the maternal and child health population in Hawaii. //2008//

/2010/. Overall, a Hispanic/Latino ethnicity for the child occurred in 12.6% of deaths in 2008, and was not recorded in <0.1% of child deaths. //2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	318293	79125	14105	2352	89729	36418	0	96564	2008
Percent in household headed by single parent	7.3	14.6	9.1	19.8	5.0	5.8	0.0	10.7	2005
Percent in TANF (Grant) families	3.7	3.3	2.0	2.1	2.1	19.0	0.0	0.0	2008

Number enrolled in Medicaid	44268	7395	522	84	10942	22638	427	2260	2005
Number enrolled in SCHIP	8630	1808	96	20	3357	2949	37	363	2005
Number living in foster home care	3344	399	75	41	309	1750	493	277	2008
Number enrolled in food stamp program	47924	9318	863	172	9248	28318	0	5	2008
Number enrolled in WIC	44719	7114	786	108	6985	7852	21734	140	2008
Rate (per 100,000) of juvenile crime arrests	4523.3	3971.3	136.4	4.7	1127.6	1636.5	0.0	463.1	2007
Percentage of high school drop-outs (grade 9 through 12)	5.1	5.5	6.8	7.2	3.2	6.7	0.0	5.8	2008

Notes - 2010

Narrative:
/2009/ An update based on 2005 data, less children (7.3%) aged 0-19 lived in a single parent household, compared to 2004 data. There was some variation by race with 19.8% of American Indian or Alaskan Native and 14.6% of white children having higher estimates than Black (9.1%), Native Hawaiian or Other Pacific Islander (NHOPI) (5.8%), and Asian (5.0%) children/2009//
/2010/Last data available was 2005 //2010//

/2009/Children living in TANF (grant) funding decreased from 5.0% to 3.4% with some variation by race in 2007. NHOPI (5.2%), white (4.9%) having higher estimates. /2009//
/2010/ 3.7% of all children lived in TANF funded families with an increase in Native Hawaiian or Other Pacific Islanders families(19.0%)//2010//

/2008/ Enrollment in Medicaid was found in 44,268 children 0-19 years of age, representing and increase to 13.5% from12.8% of children in Hawaii. //2008//
/2009/ Data was not updated since 2005 for Medicaid enrollment //2009/
/2010/ Last data available was 2005 //2010//

/2008/ There was a substantial decrease in enrollment in CHIP from 13,213 in 2004 to 8,630 in 2005. The calculation of these numbers will be verified with Medicaid and continued surveillance to determine if this 35% decrease in enrollment is accurate.//2008//
/2009/ Data was not updated since 2005 for SCHIP enrollment //2009/
/2010/ Last data available was 2005 and unable to validate with Medicaid //2010//

/2009/ The number of children reported living in foster care in 2007 was 3,884 which was a sharp decrease from 5,104 in 2005. Reasons for this significance decrease is not clear //2009/
/2010/ 3,344 children living in foster care in 2008 //2010//

/2009/ 2007 data showed a slight increase in the number of children enrolled in food stamp programs to 38,767 but minimal change with individual race groups.//2009/

/2010/ Food stamp enrollment (47,924 children) increased in 2009. NHOPI (28,318), Asian (9,248), and white (9,318) children increased compared to 2004 //2010//

/2009/ Enrollment in WIC continues with 42,380 in 2007 or 12.9% of all children //2009/
/2010/ Enrollment in WIC increased to 44,719 in 2008 //2010//

/2009/ An update based on 2005 data, shows the rate of juvenile crime arrests to be 90 per 100,000 children aged 0-19 years with the highest rate still in the Native Hawaiian or Other Pacific Islander group.//2009/
/2010/ Data from 2007 demonstrates an increase rate of 4,523.3 per 100,000 children aged 0-19 years with the highest rate in the NHOPI (1,636.5) followed by white (1,154.9) and Asian (1,127.6) children//2010//

/2009/ Data from 2007 reveals that 5.2% of children were high school drop outs with the highest proportion in American Indian or Alaskan Native, NHOPI, and Black children.//2009/
/2010/ 5.1% of children were high school drop outs with higher rates in American Indian or Alaskan Native, NHOPI, and Black children//2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	272380	45910	0	2008
Percent in household headed by single parent	6.8	29.4	0.0	2005
Percent in TANF (Grant) families	3.9	2.3	0.0	2008
Number enrolled in Medicaid	42030	1893	245	2005
Number enrolled in SCHIP	8267	155	122	2005
Number living in foster home care	3067	155	122	2008
Number enrolled in food stamp program	44440	3484	0	2008
Number enrolled in WIC	34739	9925	55	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	5.0	6.3	0.0	2008

Notes - 2010

Narrative:
/2009/ An update based on 2005 data, less children (7.3%) aged 0-19 lived in a single parent household, compared to 2004 data. 6.8% were not of the Hispanic or Latino ethnicity, compared to 29.4% of those who were of Hispanic or Latino ethnicity. Further evaluation into these disparities is suggested./2009//
/2010/ Last data available was 2005 //2010//

/2009/ There was a decrease in children living in TANF (grant) funding from 5.0% to 3.4% with some variation by ethnicity in 2007. 7.5% of those who were of Hispanic or Latino ethnicity were reported to be in TANF living environments compared to 3.4% who were not of Hispanic or Latino

ethnicity./2009//
/2010/ A similar proportion of all children were living in TANF (grant) funded families to 2007 with 3.7% in 2009. However, a small decrease was seen in those reporting Hispanic/Latino ethnicity with 2.3% and similar proportion in those who were not Hispanic/Latino//2010//

/2008/ Enrollment in Medicaid was found in 44,268 children 0-19 years of age, representing and increase to 13.5% from12.8% of children in Hawaii. //2008//
/2009/ Data was not updated since 2005 for Medicaid enrollment //2009/
/2010/ Last data available was 2005 //2010//

/2008/ There was a substantial decrease in enrollment in CHIP from 13,213 in 2004 to 8,630 in 2005. The calculation of these numbers will be verified with Medicaid and continued surveillance to determine if this 35% decrease in enrollment is accurate.//2008//
/2009/ Data was not updated since 2005 for SCHIP enrollment //2009/
/2010/ Last data available was 2005 //2010//

/2009/ The number of children reported living in foster care in 2007 was 3884 which was a sharp decrease from 5,104 in 2005. Reasons for this significance decrease is not clear //2009/
/2010/ There were 3,344 children living in foster care in 2008 //2010//

/2009/ 2007 data showed a slight increase in the number of children enrolled in food stamp programs to 38,767 but minimal change with ethnic group.//2009/
/2010/ An increase in number of children enrolled in food stamp programs with 47,924, of which 3,484 were of Hispanic/Latino ethnicity and 44,440 were not Hispanic/Latino ethnicity //2010//

/2009/ An update based on 2005 data, shows the rate of juvenile crime arrests to be 3,590 per 100,000 children aged 0-19 years.//2009/
/2010/ The data on ethnicity is not available for this indicator //2010//

/2009/ Data from 2007 reveals that 6.9% of those who reported Hispanic or Latino ethnicity compared to 5.1% without were high school dropouts.//2009/
/2010/ Similar proportion with 5.1% of children being high school drop outs. The proportions was similar to previous report by ethnicity //2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	223359
Living in urban areas	223359
Living in rural areas	94931
Living in frontier areas	0
Total - all children 0 through 19	318290

Notes - 2010

Narrative:
Children that live in different environments are exposed to various risks and specific public health programs targeting particular geographic settings may be required. The total number of children between the ages of 0 and 19 years in Hawaii in 2005 was 339,000.A high proportion of Hawaii's

children between the ages of 0 and 19 live in urban (70.0%) compared to rural (30.0%) areas. No children were classified as living in a frontier area. All the children classified as living in an urban area also lived in a metropolitan area.

/2008/ Similar to previous year. //2008//
/2009/ Same as previous year, 2005 last year of available data./2009//
/2010/ 70.2% of resident children in Hawaii lived in urban settings and 29.8% lived in rural areas. All the children classified as living in an urban area also lived in a metropolitan area and Hawaii does not have a frontier designation //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	1245051.0
Percent Below: 50% of poverty	2.1
100% of poverty	8.1
200% of poverty	25.7

Notes - 2010
Hawai‘i State Department of Health population estimate. The data is by calendar year and comes from a state-wide random sample survey and is subject to sampling variability. There continues to be problems with the survey. Data from the 2006, 2007, or 2008 surveys are currently not available.

Hawai‘i State Department of Health population estimate. The data is by calendar year and comes from a state-wide random sample survey and is subject to sampling variability. There continues to be problems with the survey. Data from the 2006, 2007, or 2008 surveys are currently not available.

Hawai‘i State Department of Health population estimate. The data is by calendar year and comes from a state-wide random sample survey and is subject to sampling variability. There continues to be problems with the survey. Data from the 2006, 2007, or 2008 surveys are currently not available.

Hawai‘i State Department of Health population estimate. The data is by calendar year and comes from a state-wide random sample survey and is subject to sampling variability. There continues to be problems with the survey. Data from the 2006, 2007, or 2008 surveys are currently not available.

Narrative:
Just over 1.2 million people (1,222,281) lived in Hawaii in 2004. Of these, 3.7% live with incomes below 50% of the federal poverty level, 11.9% live at 100% of the federal poverty level, and 32.4% live at 200% of the federal poverty level. Hawaii has seen a steady increase in those living in poverty over the past 4 years. Could impact eligibility for specific programs and likely varies significantly by race and ethnicity. Programs that identify those at poverty may allow better access to health care and various state programs which could influence the health of children.

/2008/ Similar to previous year. //2008//

/2009/ Same as previous year, 2005 last year of available data./2009//

/2010/ The estimated population in 2005 for the state was just over 1.2 million persons (1,245,051) with 2.1% living below 50% of the federal poverty level, 8.1% living below 100% of the federal poverty level, and 25.7% living below 200% of the federal poverty level. No further updates are available. //2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	327422.0
Percent Below: 50% of poverty	2.7
100% of poverty	9.4
200% of poverty	32.3

Notes - 2010
Hawai‘i State Department of Health population estimate. The data is by calendar year and comes from a state-wide random sample survey and is subject to sampling variability. There continues to be problems with the survey. Data from the 2006, 2007, or 2008 surveys are currently not available.

Hawai‘i State Department of Health population estimate. The data is by calendar year and comes from a state-wide random sample survey and is subject to sampling variability. There continues to be problems with the survey. Data from the 2006, 2007, or 2008 surveys are currently not available.

Hawai‘i State Department of Health population estimate. The data is by calendar year and comes from a state-wide random sample survey and is subject to sampling variability. There continues to be problems with the survey. Data from the 2006, 2007, or 2008 surveys are currently not available.

Hawai‘i State Department of Health population estimate. The data is by calendar year and comes from a state-wide random sample survey and is subject to sampling variability. There continues to be problems with the survey. Data from the 2006, 2007, or 2008 surveys are currently not available.

Narrative:
Eligibility for several programs (e.g. Medicaid and SCHIP) are partly determined by family income and poverty levels. Participation in these programs can positively influence health. There were 323,620 resident children between 0 and 19 years of age that lived in Hawaii in 2004. Of these, 5.8% lived in families with incomes below 50% of the federal poverty level, 16.0% lived at 100% of the federal poverty level, and 41.4% lived at 200% of the federal poverty level. Programs that identify those at poverty may allow better access to needed care are needed and may be identified within specific race/ethnic groups.

/2008/ Similar to previous year. //2008//

/2009/ Same as previous year, 2005 last year of available data./2009//

/2010/ The estimated population of children aged 0-19 years in 2005 for the state was 327,422. Of these children, 2.7% lived below 50% of the federal poverty level, 9.4% lived below 100% of the federal poverty level, and 32.3% lived below 200% of the federal poverty level. No further updates are available //2010//

F. Other Program Activities

PRESCHOOL DEVELOPMENTAL SCREENING PROGRAM (PDSP) is a statewide program that promotes early identification and intervention of developmental, learning, behavioral, and social-emotional problems for children age 3 to kindergarten entry. PDSP trains community resources, including early education/care providers, in standardized screening. PDSP provides consultation and facilitates follow-up, including evaluation, providing intervention strategies for families and early education/care providers, referral to the Department of Education for special education, referral to other community resources, and monitoring.

THE GENETICS PROGRAM develops statewide genetics activities in coordination with other public/private organizations; assesses genetic needs and develops policies and programs to meet the needs; promotes the prevention, detection, and management of genetic disorders; and provides genetics education for the professional and lay communities. The "Western States Genetic Services Collaborative" is a multi-state grant funded by the MCH Bureau to develop and pilot a regional practice model that improves access to specialty genetic services, comprehensive primary care, and care coordination for Hawaii, Idaho, and Oregon children with heritable disorders; and 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. "Hawaii Sickle Cell Disease Project", funded by the MCH Bureau, will develop sickle cell disease and trait clinical services, education, materials, and training opportunities for health professionals and public health staff.
/2008/ The regional practice model to improve access also includes Washington, Alaska, and Guam.//2008//

/2009/ As part of the Western States Genetics Services Collaborative, the Genetics Program also completed a Genetics and Newborn Screening (NBS) needs assessment and plan for Guam. Using the information, the Genetics Program is assisting Guam to improve their NBS testing and follow-up services.//2009//

/2010/ The program continues to work with Guam to develop a comprehensive newborn screening follow-up program. //2010//

HAWAII BIRTH DEFECTS PROGRAM (HBDP) is a population-based active surveillance system for birth defects and other adverse pregnancy outcomes. Since 1988, it has been an accurate, complete, and timely source of statewide data on infants with specific birth defects, and pregnancies resulting in adverse reproductive outcomes. 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 now funded from $10 of each marriage license fee which goes into a special fund, and established as a program in the DOH as a result of a law passed by the 2002 State Legislature (H.R.S. SS321-421).

/2007/ The DOH is now in the process of establishing HBDP civil service positions, as part of the transition of HBDP to a DOH program.//2007//

/2010/ The DOH has established the HBDP civil service positions and is now recruiting for

staff.//2010//

HEALTHY CHILD CARE HAWAII (HCCH) is a collaborative project of FHSD/CSHNB, University of Hawaii Department of Pediatrics, American Academy of Pediatrics-Hawaii Chapter, and Department of Human Services. HCCH promotes the health and safety of young children in child care, based on the national health and safety performance standards in child care settings. HCCH recruits, trains, and connects health consultants to child care programs; trains pediatric residents in providing presentations on health topics for families and staff at child care sites; provides education/information at conferences; and other activities. HCCH was previously funded by the MCH Bureau. DHS began providing funding in June 2002, and is now providing the only funding support for HCCH for FY2006. CSHNB provides in-kind support.

/2008/ Beginning July 2007, DHS is contracting for HCCH services with the University of Hawaii/School of Medicine/Department of Pediatrics, with CSHNB continuing as a collaborating partner.//2008//

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.
/2009/ Hawaii Student Television was contracted to produce a Safe Sleep DVD. The DVD is accompanied by training and an evaluation. The video won a 2008 Western Regional Television Award for Excellence. //2009//

/2010/ Safe Sleep flyers have been translated into Chuukese, Marshallese and Spanish.//2010//

PARENTING SUPPORT PROGRAMS include: HomeReach- short-term home visitation services to resolve a parenting concern or family crisis, Mobile Outreach- activities and programs to isolated or homeless families that promote age-appropriate parent-child interaction, communication, and positive discipline, Community-based Parent Support Groups (via The Baby Hui)- parenting and appropriate child development/guidance support though volunteer led peer parent groups, Respite Services- care giving relief, parent education and support on Oahu to high risk families having crises or difficulties with parenting and family stress, Services for Children who have Witnessed Violence (via The Family Peace Center)- intended to help children cope with their emotional responses to violence and by helping the family create a safe, stable, and nurturing environment for the child by teaching parents to have age-appropriate expectations and an awareness of the effects of violence on children.
/2009/ Short term home visitation services have been incorporated into the Parent Line. Services for Parents of Children Exposed to Violence are now being provided by Parents and Children Together.//2009//

/2010/ Funding for the Children who Witnessed Violence was eliminated by the 2009 Legislature beginning July 2009.//2010//

THE PARENT LINE is a free, statewide telephone warm line that provides support, encouragement, informal counseling, information, and referral to callers experiencing concerns about their child's development and behavior or who have issues regarding family stresses or questions on community resources. The Parent Line Office also publishes and distributes: Keiki ‘O Hawaii which is an early childhood developmental newsletter distributed in the hospitals to first-time parents, the Teddy Bear Post parent education newsletters, distributed to families of preschool age children, the Keiki ‘O Hawaii Parent Resource Directory which gives parents information on accessing services and is distributed to parents of young children and to agencies helping them, and the A Happy Start brochure distributed to parents of children who are preparing

to enter kindergarten.

/2007/ THE HAWAII HEALTHY START ADVISORY TASK FORCE (HSATF) HSAFT was formed in response to a 2005 legislation resolution to work with the Hawaii Healthy Start (HHS) providers to restructure the program for greater effectiveness. HSATF has reviewed evidence-based practices, improved the effectiveness of interventions to prevent child abuse and neglect; increased prenatal referrals to the program, extended the period of eligibility, and refocused service delivery on family risk factors. //2007//

/2008/ The Healthy Start program completed a task force report to the legislature regarding its efforts to improve program performance. An additional $1.6M of TANF dollars has been appropriated for additional training and to reduce client/staff ratios for the clinical specialist and child development specialist which strengthens the home visitation component of the program. //2008//

/2009/ The HSATF ended in 2006.//2009//

/2010/ Due to substantial state budget cuts to the Healthy Start program services are being restructured. Hospital screening for families at-risk for child maltreatment or neglect are eliminated. Home visiting services continue to be offered statewide with referral sources utilizing the Hawaii Keiki Information Services System (H-KISS) as the central point of contact. Care coordination for IDEA Part C direct services are no longer available through the program. Due to limited resources, caseloads have also been restricted.//2010//

G. Technical Assistance

See Form 15 for Technical Assistance request.

V. Budget Narrative

A. Expenditures

EXPENDITURES 2004

Significant Budget Variations -- Form 3 (Fiscal Year 2004)

The total Title V Block Grant amount awarded to the State in fiscal year 2004 was $2,484,701. Out of this total grant award, a sum of only $684,824 was expended in federal fiscal year 2004 due to carryovers from fiscal year 2003. Actual expenditures for the category "Unobligated Balance" ($1,706,605) was higher than the budgeted amount of $1,196,537 used for the FY 2004 Title V application. (The unobligated balance was underestimated for the FY 2004 Title V application.) The actual expenditures for the category "Program Income" was $1,443,778 less than the budgeted amount because of a significant backlog in reimbursements from Medicaid for the Healthy Start and Early Intervention Programs. Actual expenditures for the category "Other Federal Funds" was $6,842,079 less than the budgeted amount of $42,763,132 primarily due to a segregation in accounting of the infant formula manufacturer's rebates under WIC. The rebates will no longer be included as part of the WIC grant commencing with the FY 2006 Title V grant application.

Significant Budget Variations -- Form 4 (Fiscal Year 2004)

In fiscal year 2004, the State's expenditures for the category "Children with Special Healthcare Needs" was $1,661,346 less than what was budgeted for because of a significant backlog in reimbursements from Medicaid for the Healthy Start and Early Intervention Programs. In fiscal year 2004, the State's expenditures for the category "Administration" was $281,271 more than what was budgeted for because three neighbor island District Health Office nurse positions and clerical staff were not included in the fiscal year 2004 budget.

Significant Budget Variations -- Form 5 (Fiscal Year 2004)

The State expended $1,885,989 less than budgeted for under the category "Enabling Services" primarily due to reduced spending by the Healthy Start Program and a significant backlog in reimbursements from Medicaid for the Healthy Start and Early Intervention Programs to pay for services under this category.

Expended amounts for the category "Infrastructure Building Services" was $825,057 less than what was budgeted for in fiscal year 2004. As a whole, the State's expenditures were less than what was budgeted for in fiscal year 2004 and this is reflective of the amounts expended for "Infrastructure Building Services."

/2007/ EXPENDITURES 2005

Significant Budget Variations -- Form 3 (Fiscal Year 2005)

The total Title V Block Grant amount awarded to the State in fiscal year 2005 was $2,392,416. Out of this total grant award, a sum of only $1,044,283 was expended in federal fiscal year 2005 due to carryovers from fiscal year 2004. Actual expenditures for the category "Unobligated Balance" ($1,840,049) was higher than the budgeted amount of $1,405,951 used for the FY 2005 Title V application. (The unobligated balance was underestimated for the FY 2005 Title V application.) The actual expenditures for the category "Program Income" was $678,604 more than the budgeted amount due to increased service requirements for both the Healthy Start and Early Intervention Programs.

Significant Budget Variations -- Form 4 (Fiscal Year 2005)

In fiscal year 2005, the State's expenditures for the category "Children with Special Healthcare Needs" was $1,291,759 more than what was budgeted for due to an increase in mandated services for the Early Intervention Program. These additional services were funded by State funds and Medicaid reimbursements.

Significant Budget Variations -- Form 5 (Fiscal Year 2005)

No significant variances. //2007//

/2008/ EXPENDITURES 2006

Significant Budget Variations -- Form 3 (Fiscal Year 2006)

The total Title V Block Grant amount awarded to the State in fiscal year 2006 was $2,300,034. Out of the amount awarded, a sum of only $1,509,531 was expended in federal fiscal year 2006 due to carryovers from fiscal year 2005. The actual expenditures of $1,358,994 for the category "Unobligated Balance" was higher than the budgeted amount of $1,090,055 used for the FY 2006 Title V application due to an under estimation of the unobligated balance.

The amount of funds actually expended under the category "State Funds" was $5,050,772 more than the budgeted amount which was due largely in part to a total of $4,200,928 in emergency appropriations made by the 2006 Hawaii State Legislature for both the Healthy Start Program and the Early Intervention Services Program.

The amount of funds actually expended under the category "Other Funds" was $585,970 less than the budgeted amount which was mainly due to a reclassification of hospital subsidy expenditures in the fourth quarter of federal fiscal year 2006 from "Other Funds" to "State Funds."

The amount actually expended under the category "Program Income" was $1,259,434 more than what was budgeted for under this category. This was due to an increase in expenditures for the Healthy Start Program from the Early Intervention Special Fund which is classified as a program income account.

Significant Budget Variations -- Form 4 (Fiscal Year 2006)

The budgeted amount of $8,259,181 for the category "Infants < 1 Year Old" was less than the actual expenditures of $10,590,011 due largely in part to a $1,000,000 emergency appropriation made by the 2006 Hawaii State Legislature and additional expenditures from the Early Intervention Special Fund account to meet shortfalls for the Healthy Start Program.

The budgeted amount of $9,710,839 for the category "Children 1 to 22 Years Old" was less than the actual expenditures of $10,755,982 due largely in part to the emergency appropriation made by the 2006 Hawaii State Legislature for the Healthy Start Program.

The budgeted amount of $15,731,577 for the category "Children with Special Healthcare Needs" was less than the actual expenditures of $18,283,457 due largely in part to a $3,200,928 emergency appropriation made by the 2006 Hawaii State Legislature to meet shortfalls for the Early Intervention Services Program.

The budgeted amount of $1,599,295 for the category "Administration" was more than the actual expenditures of $1,350,058. This was due to an over estimation of expenditures for the year.

Significant Budget Variations -- Form 5 (Fiscal Year 2006)

The budgeted amount for the category "Enabling Services" was $16,343,615 in fiscal year 2006 and the amount actually expended under this category was $19,547,063, a difference of $3,203,448. The reason for the increase in expenditures over the budgeted amount was due to an emergency appropriation made by the 2006 Hawaii State Legislature for both the Early Intervention Services Program and the Healthy Start Program.

The budgeted amount for the category "Population Based Services" was $6,298,658 in fiscal year 2006. The actual amount expended in this category was $7,502,338, a difference of $1,203,680. The primary reason for the increase in expenditures over the budgeted amount was due to a $1 million emergency appropriation made by the 2006 Hawaii State Legislature for the Healthy Start Program. //2008//

/2009/ EXPENDITURES 2007

Significant Budget Variations -- Form 3 (Fiscal Year 2007)

The total Title V Block Grant amount awarded to the State in fiscal year 2007 was $2,300,034. Out of the amount awarded, a sum of only $1,316,611 was expended in federal fiscal year 2007 due to carryovers from fiscal year 2006. The actual expenditures of $1,170,975 for the category "Unobligated Balance" was higher than the budgeted amount of $683,506 used for the FY 2007 Title V application due to an under estimation of the unobligated balance.

The amount of funds actually expended under the category "State Funds" was $1,126,535 more than the budgeted amount which was due largely in part to an emergency appropriation made by the 2007 Hawaii State Legislature via Act 32 to meet shortfalls relative to the Early Intervention Services Program.

The amount of funds actually expended under the category "Other Funds" was $529,223 less than the budgeted amount. This was due to less than anticipated expenditures for the Child Death Review Program and several grants and subsidies in FY 2007.

The amount actually expended under the category "Program Income" was $2,721,859 more than what was budgeted for under this category. This was due to an increase in expenditures for the Early Intervention Program from the Early Intervention Special Fund which is classified as a program income account.

Significant Budget Variations -- Form 4 (Fiscal Year 2007)

The budgeted amount of $8,804,312 for the category "Infants < 1 Year Old" was less than the actual expenditures of $10,049,717 due largely in part to additional expenditures made from the Early Intervention Special Fund account to meet shortfalls for the Healthy Start Program.

The budgeted amount of $12,041,285 for the category "Children with Special Healthcare Needs" was less than the actual expenditures of $13,596,973 due largely in part to an emergency appropriation made by the 2007 Hawaii State Legislature via Act 32 to meet shortfalls for the Early Intervention Services Program.

The budgeted amount of $1,492,106 for the category "Administration" was more than the actual expenditures of $1,156,244. This was due to an over estimation of expenditures for the year.

Significant Budget Variations -- Form 5 (Fiscal Year 2007)

The budgeted amount for the category "Enabling Services" was $15,399,961 in fiscal year 2007 and the amount actually expended under this category was $18,330,653, a difference of $2,930,692. The reason for the increase in expenditures over the budgeted amount was due to

an emergency appropriation made by the 2007 Hawaii State Legislature via Act 32 to meet shortfalls for the Early Intervention Services Program.

The budgeted amount for the category "Population Based Services" was $4,825,657 in fiscal year 2007. The actual amount expended in this category was $5,327,751, a difference of $502,094. The primary reason for the increase in expenditures over the budgeted amount was due to additional expenditures from the Early Intervention Special Fund account to cover shortfalls for the Healthy Start Program.

The budgeted amount for the category "Infrastructure Building Services" was $7,166,981 in fiscal year 2007. The actual amount expended in this category was $6,266,834, a difference of $900,147. This was mainly due to a large number of vacant positions in the Early Intervention Services Program. //2009//

/2010/ EXPENDITURES 2008

Significant Budget Variations -- Form 3 (Fiscal Year 2008)

The total Title V Block Grant amount awarded to the State in fiscal year 2008 was $2,265,527. Out of the amount awarded, a sum of only $1,307,350 was expended in federal fiscal year 2008 due to carryovers from fiscal year 2007. The actual expenditures of $908,299 for the category "Unobligated Balance" was higher than the budgeted amount of $328,464 used for the FY 2008 Title V application due to an under estimation of the unobligated balance.

The amount of funds actually expended under the category "State Funds" was $2,478,616 less than the budgeted amount in fiscal year 2008. The decrease in expenditures was largely due to executive and legislative reductions to purchase of service contracts for the Family Planning Program, Healthy Start Program, and the Rural Hospitals (Hana Health, Molokai General Hospital, Wahiawa General Hospital, and Waianae Coast Comprehensive Health Center) in the fourth quarter of federal fiscal year 2008.

The amount of funds actually expended under the category "Other Funds" was $577,651 less than the budgeted amount. This was due to less than anticipated expenditures for the Child Death Review and Full Inclusion Programs in fiscal year 2008.

The amount actually expended under the category "Program Income" was $2,231,917 more than what was budgeted for under this category. This was due to an increase in expenditures for the Early Intervention Program from the Early Intervention Special Fund which is classified as a program income account.

Significant Budget Variations -- Form 4 (Fiscal Year 2008)

There were no significant differences between budgeted amounts and actual amounts expended for all Federal-State MCH Block Grant Partnership categories in fiscal year 2008.

Significant Budget Variations -- Form 5 (Fiscal Year 2008)

The budgeted amount for the category "Infrastructure Building Services" was $7,728,366 in fiscal year 2008 and the amount actually expended under this category was $6,925,722, a difference of $802,644. This was mainly due to a large number of vacant positions in the Early Intervention Services Program.

There were no other significant differences between budgeted amounts and actual amounts expended for all other categories. //2010//

B. Budget

BUDGET 2006

The State's maintenance of effort level from 1989 is $11,910,549 and the State's overmatch in fiscal year 2006 is $30,715,145. There is no continuation funding for special projects or special consolidated projects in fiscal year 2006.

Significant Budget Variations -- Form 3 (Fiscal Year 2006)

The "Federal Allocation" category for fiscal year 2006 amounts to $2,381,011. This figure is based on last year's grant award.

The category "Unobligated Balance" is estimated to be $1,090,055. This estimated balance from the fiscal year 2005 grant will be used to fund positions within the Family Health Services Division which provide infrastructure building related services. The Family Health Services Division has approximately fifty Title V Block Grant funded positions. Historically speaking, the Division has had a substantial amount of unobligated funds which got carried over from one fiscal year into the next. This conservative approach was taken to ensure that there would be adequate funds to cover payroll costs for new positions and to fund annual increases in the fringe benefit and collective bargaining rates for existing employees.

There has been an increase of $3,250,365 in the category "State Funds" from fiscal year 2005 to fiscal year 2006 primarily due to an appropriation of $1,700,000 for primary care services to the uninsured and an appropriation of $1,000,000 for grants to rural hospitals. There has been a $7,669,698 decrease in the "Other Funds" category from fiscal year 2005 to fiscal year 2006 primarily due to an approximate $5,200,000 reduction in the Tobacco Settlement Funds for the Health Start Program. The budget for the category "Program Income" has increased by $1,568,567 due to projected increases in Medicaid reimbursements for the Early Intervention and Healthy Start Programs. There is a reduction of approximately $4,108,007 in the "Other Federal Funds category" from fiscal year 2005 to fiscal year 2006 primarily due to the segregation in accounting of the infant formula manufacturer's rebates under WIC. There also have been a number of federal grants which have terminated as of fiscal year 2005.

Significant Budget Variations -- Form 4 (Fiscal Year 2006)

There was an increase of $734,491 increase from fiscal year 2005 to fiscal year 2006 in the category "Pregnant Women." The reason for this increase is due to the inclusion of a portion of the Domestic Violence Prevention and Sexual Assault Programs into this category. There is a proportionate budget decrease of $3,244,691 in the category "Infants < 1 year old" from fiscal year 2005 to fiscal year 2006 primarily due to the reduction of Tobacco Settlement Funds for the Healthy Start Program. Likewise, there is a proportionate budget decrease of $2,582,438 in the category "Children 1 to 22 years old" primarily due to the reduction of Tobacco Settlement Funds for the Healthy Start Program. The budget category "Children with Special Healthcare Needs" was increased by $1,878,896 from fiscal year 2005 to fiscal year 2006 primarily due to projected increases in Medicaid reimbursements for the Early Intervention Program. An increase of $210,525 under the category "Administration" from fiscal year 2005 to fiscal year 2006 is due to projected collective bargaining and fringe benefit increases.

Significant Budget Variations -- Form 5 (Fiscal Year 2006)

There is a decrease of $3,170,730 for the category "Enabling Services" from fiscal year 2005 to fiscal year 2006 which is due primarily to a $5,200,000 reduction in Tobacco Settlement funds for the Healthy Start Program. (Approximately 60% of the Tobacco Settlement funds for the Healthy Start Program was targeted towards Enabling Services in last fiscal year's grant application.)

Finally, the category "Infrastructure Building Services" reflects a decrease of $1,188,814 from fiscal year 2005 to fiscal year 2006. The reasons for this decrease include: 1) a reduction in infrastructure building services for the Healthy Start Program from 10% in last fiscal year's grant application to 5% in this fiscal year's grant application due to position vacancies; 2) deletion of infrastructure building services for the School Based Initiative Program which was transferred to another staff office within the Department of Health; and 3) a reduction in funds for the Child Death Review Program which is classified entirely under the infrastructure building services category.

/2007/ BUDGET 2007

The State's maintenance of effort level from 1989 is $11,910,549 and the State's overmatch in fiscal year 2007 is $28,217,143. There is no continuation funding for special projects or special consolidated projects in fiscal year 2007.

Significant Budget Variations -- Form 3 (Fiscal Year 2007)

The "Federal Allocation" category for fiscal year 2007 amounts to $2,300,034. This figure is based on last year's grant award.

The category "Unobligated Balance" is estimated to be $683,506. The unobligated balance of $683,506 is at an all time low and the Family Health Services Division will need to focus on restructuring its workforce and services in the coming year in order to meet anticipated Title V financial shortfalls. The Family Health Services Division is estimating that $2,983,540 in Title V funds will be available in fiscal year 2007 ($2,300,034 grant award + $683,506 unobligated balance = $2,983,540). However, the annual payroll and fringe benefit costs for the approximately forty (40) Title V funded positions is estimated to be $3,059,705 in federal fiscal year 2007.

Significant Budget Variations -- Form 4 (Fiscal Year 2007)

There was a decrease of $3,690,292 from fiscal year 2006 to fiscal year 2007 in the category "Children with Special Healthcare Needs." The decrease reflects the projected fiscal year 2007 balance in the Early Intervention Special Fund which has decreased substantially from the prior year. There were no other significant categorical budget variations between fiscal year 2006 and fiscal year 2007.

Significant Budget Variations -- Form 5 (Fiscal Year 2007)

There is a decrease of $1,473,001 in the category "Population-Based Services" from fiscal year 2006 to fiscal year 2007 which is primarily due to: a) a transfer of the Sex Assault Program ($923,783) to the Department of the Attorney General effective July 1, 2006; and b) a reduction in the percentage of funds allocated under this category to the Healthy Start and Domestic Violence Prevention Programs. There were no other significant categorical budget variations between fiscal year 2006 and fiscal year 2007. //2007//

/2008/ BUDGET 2008

The Family Health Services Division was successful in advocating for the expansion of several of its programs during the 2007 legislative session. The Early Intervention program received an emergency budget appropriation of $4.4 million to cover budget shortfalls this year because of increased number of children seen. In addition, $6.7 million has been added to the Early Intervention Services base budget for a total annual appropriation of $19.3 million.

Because of the continuing erosion of Hawaii's Title V allocation, a decision was made in September 2006 to eliminate the Pre-school Developmental Screening Program. Legislative

efforts were successful in having the five positions and operating expenses converted from Title V to state general funds. This prevents the closure of the program which was targeted for September 2007.

With strong community stakeholder support and advocacy, family planning services received an increase of $1.2 million in general funds and $463,000 in TANF funds for both years of the biennium. Primary care services received an increase of $3.8 million for each year of the biennium.

The Healthy Start Program will receive $1.6 million additional TANF funding to implement task force recommendations to reduce the client/worker ratio for child development and clinical services, and to expand training of the home visitors.

A total 15.5 new positions were added to the Division programs: 7 for EIS; 5 for CSHNB, 1 MCHB, 2.5 for the Division effort.

The State's maintenance of effort level from 1989 is $11,910,549 and the State's overmatch in fiscal year 2008 is $37,993,616. There is no continuation funding for special projects or special consolidated projects in fiscal year 2008.

Significant Budget Variations -- Form 3 (Fiscal Year 2008)

The "Federal Allocation" category for fiscal year 2008 amounts to $2,300,034. This figure is based on the fiscal year 2006 grant award since the final grant award for fiscal year 2007 has not been determined.

The category "Unobligated Balance" is projected to be $328,464. This amount is less than one-half of the unobligated balance amount for fiscal year 2007 ($683,506). The Family Health Services Division is estimating that $2,628,498 in Title V funds will be available in fiscal year 2008 ($2,300,034 grant award + $328,464 unobligated balance = $2,628,498). The annual payroll, fringe benefit and operating costs are estimated to be $2,540,402 in federal fiscal year 2008, leaving a projected unobligated balance of only $88,096 as of September 30, 2008. The Family Health Services Division will continue to implement various cost containment strategies in the coming fiscal year to meet anticipated Title V financial constraints.

The category "State Funds" has increased by $13,076,022 from fiscal year 2007 to fiscal year 2008. As mentioned in the introductory paragraph above, FHSD was successful in advocating for the expansion of several of its programs during the 2007 legislative session. The major program expansions and dollar amounts are described in the introductory paragraph.

The category "Other Funds" has decreased by $3,692,501 from fiscal year 2007 to fiscal year 2008. This decrease is due primarily to the elimination of roughly $3 million from the Tobacco Settlement funds previously used to pay for Healthy Start services.

Significant Budget Variations -- Form 4 (Fiscal Year 2008)

There was an increase in the budgeted category "Children with Special Health Care Needs" from $12,041,285 in fiscal year 2007 to $19,710,722 in fiscal year 2008 due in large part to a $6.7 million appropriation by the 2007 Hawaii State Legislature for early intervention services. There were no other significant categorical budget variations between fiscal year 2007 and fiscal year 2008.

Significant Budget Variations -- Form 5 (Fiscal Year 2008)

There is an increase of $6,058,625 in the category "Direct Health Care Services" and an increase of $2,462,174 in the budgeted category "Enabling Services" from fiscal year 2007 to fiscal year

2008 due largely in part to a $6.7 million appropriation by the 2007 Hawaii State Legislature for early intervention services. There were no other significant categorical budget variations between fiscal year 2007 and fiscal year 2008. //2008//

/2009/ BUDGET 2009

The State's maintenance of effort level from 1989 is $11,910,549 and the State's overmatch in fiscal year 2009 is $35,346,424. There is no continuation funding for special projects or special consolidated projects in fiscal year 2009.

Significant Budget Variations -- Form 3 (Fiscal Year 2009)

The "Federal Allocation" category for fiscal year 2009 amounts to $2,265,527. This figure is based on the fiscal year 2008 grant award since the final grant award for fiscal year 2009 has not been determined.

The category "Unobligated Balance" is projected to be $497,888. The unobligated balance plus the Title V grant award for fiscal year 2009 may not be enough to meet payroll and fringe benefit costs for the year. The Family Health Services Division will continue to implement various cost containment strategies in the coming fiscal year to meet anticipated Title V financial constraints.

The category "Other Funds" has decreased by $582,237 from fiscal year 2008 to fiscal year 2009. This decrease is primarily due to the reclassification of programs from "Other Funds" to "State Funds."

Significant Budget Variations -- Form 4 (Fiscal Year 2009)

There is a decrease in the budgeted category "Pregnant Woman" from $5,368,430 in fiscal year 2008 to $3,436,791 in fiscal year 2009 due to the shifting of family planning services to the categories "Children 1-22 Years Old" and "Others."

The category "Infants < 1 Year Old" has increased from $9,200,190 in fiscal year 2008 to $10,414,628 in fiscal year 2009. This was primarily due to the Hawaii State Legislature's appropriation of TANF funds for the Healthy Start Program in fiscal year 2009.

There was an increase in the budgeted category "Others" from $7,197,686 in fiscal year 2008 to $8,696,855 in fiscal year 2009 due in large part to the partial reclassification of family planning services from "Pregnant Women" into this budget category.

Significant Budget Variations -- Form 5 (Fiscal Year 2009)

There is an increase of $2,502,843 in the budgeted category "Enabling Services" and a $1,437,200 increase in the category "Population-Based Services" from fiscal year 2008 to fiscal year 2009 due largely in part to a $1.6 million appropriation by the Hawaii State Legislature of TANF funds for the Healthy Start Program and an appropriation of $463,587 for family planning services in fiscal year 2009.

The category "Infrastructure Building Services" has increased by $2,069,752 from fiscal year 2008 to fiscal year 2009. This increase was mainly due to budget revisions from other "pyramid" categories into the "Infrastructure Building Services" category by Program Managers for the fiscal year 2009 application. //2009//

/2010/ BUDGET 2010

The State's maintenance of effort level from 1989 is $11,910,549 and the State's overmatch in fiscal year 2010 is $13,483,656. There is no continuation funding for special projects or

special consolidated projects in fiscal year 2010.

Significant Budget Variations -- Form 3 (Fiscal Year 2010)

The "Federal Allocation" category for fiscal year 2010 amounts to $2,274,447. This figure is based on the fiscal year 2009 grant award since the final grant award for fiscal year 2010 has not been determined.

The category "Unobligated Balance" is estimated to be $437,770. The unobligated balance plus the Title V grant award for fiscal year 2010 is projected to be just enough to meet payroll and fringe benefit costs for Title V funded positions for the year. The Family Health Services Division will continue to implement various cost containment strategies in the coming fiscal year to meet Title V financial constraints.

A significant budget variation in fiscal year 2010 pertains to the category "State Funds." Due to the State's worsening economic environment, FHSD experienced a 44% reduction in its total general fund appropriation, from $45,109,529 (adjusted for categorical reclassifications) in fiscal year 2009 to $25,394,205 in fiscal year 2010. The reductions were primarily due to executive and legislative reductions as follows:

• The Healthy Start Program's State funds (purchase of service contracts, operating, and 2 vacant positions) was reduced by $11,563,000. The 2009 Hawaii State Legislature, however, restored $3,000,000 by utilizing the Tobacco Settlement funds.
• The Primary Care and Rural Hospital purchase of service contracts to Federally Qualified Health Centers ("FQHC") received State fund reductions of $5,691,526. The State funds, however, were replaced by the community health centers special fund which was established via Act 316/HSL 2006 (cigarette tax legislation).
• The Early Intervention Services Program ("EIS") received a reduction of $1,719,123 in State funds (primary to their purchase of service contracts). The 2009 Hawaii State Legislature, however, restored $1,000,000 by utilizing the Tobacco Settlement funds. The EIS Program also received $2,139,843 in grants under the American Recovery and Reinvestment Act ("ARRA").
• A sum of $900,000 in State funds was reduced from the following purchase of service contracts: a) BabySAFE - $669,557; b) additional Family Planning reductions - $31,120; c) Perinatal Support - $94,229; and d) Parenting Support - $105,094.

The "Other Funds" category has increased by $1,544,659 from fiscal year 2009 to fiscal year 2010. This increase is primarily due to the reclassification of TANF funds earmarked for the Healthy Start and Family Planning purchase of service contracts from "State Funds" to "Other Funds" in fiscal year 2010.

Finally, the category "Program Income" has increased by $10,442,284 from fiscal year 2009 to fiscal year 2010. The increase in Program Income is primary due to the following:

• Addition of $5,691,526 in community health centers special fund dollars (primary care and rural hospital FQHC purchase of service contracts) to the "Program Income" category. (As mentioned previously, State Funds for the primary care and rural hospital FQHC contracts has been replaced by the community health centers special fund).
• Addition of $3,000,000 in Tobacco Settlement funds for the Healthy Start Program to the "Program Income" category.
• Addition of $1,000,000 in Tobacco Settlement funds for the Early Intervention Services Program to the "Program Income" category.

Significant Budget Variations -- Form 4 (Fiscal Year 2010)

There is a decrease in the budget category "Pregnant Woman" from $3,436,791 in fiscal

year 2009 to $2,757,274 in fiscal year 2010. This decrease is due to the executive and legislative reductions in State Funds for this budget category in fiscal year 2010.

The category "Infants < 1 Year Old" has decreased from $10,414,628 in fiscal year 2009 to $5,038,892 in fiscal year 2010. This decrease is due to the executive and legislative reductions in State Funds for this budget category in fiscal year 2010.

The budget category "Children 1 to 22 years old" has decreased from $10,768,239 in fiscal year 2009 to $7,431,859 in fiscal year 2010. This decrease is due to the executive and legislative reductions in State Funds for this budget category in fiscal year 2010.

Significant Budget Variations -- Form 5 (Fiscal Year 2010)

There is a decrease of $6,696,033 in the budget category "Enabling Services" and a $899,893 decrease in the category "Population-Based Services" from fiscal year 2009 to fiscal year 2010 due to the executive and legislative reductions in State funds for fiscal year 2010.

The category "Infrastructure Building Services" has decreased by $1,649,585 from fiscal year 2009 to fiscal year 2010. This decrease was due to the executive and legislative reductions in State Funds for fiscal year 2010. //2010//

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.