



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

**State Narrative for
Hawaii**

**Application for 2009
Annual Report for 2007**



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I. General Requirements

A. Letter of Transmittal

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

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

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; expires May 31, 2009.

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. Copies of the report are 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//

II. Needs Assessment

In application year 2009, 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 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

Organizationally, 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 needs assessment 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 assessment 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 needs assessment 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 next 5-year needs assessment is due in 2010. The Title V Steering Committee and key program staff will begin planning for the next needs assessment 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 three 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 program 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.

Needs assessment 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 in July 2007. Dr. Acuna provided Title V agency staff with an overview on the importance of needs assessment through his presentation also held in July. Arrangements are being made to conduct a 2-day training with Dr. Acuna in October 2008 during this next site visit. Dr. Acuna also met with FHSD programs to identify and discuss data needs.

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 training will be conducted by Dr. Carolyn Fowler, Assistant Professor at Johns Hopkins Bloomberg School of Public Health & Director of Injury Prevention Program, Baltimore County Department of Health. 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. Where appropriate, lessons from the training will be incorporated into the needs assessment planning.

Planning for the needs assessment will be completed by the end of 2008. The process utilized in the last needs assessment will provide the framework for the next assessment. The October needs assessment training will be used to 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 needs assessment, 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 also being developed utilizing 6-years of PRAMS data. The databook and fact sheets will help engage more stakeholders to provide input to the Title V annual report and needs assessment.//2009//

III. State Overview

A. Overview

GEOGRAPHY

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

The State is composed of 7 populated islands located in 4 major counties: Hawaii, Maui, O'ahu, and Kaua'i (see attached Figure 1). The county is the lowest civil subdivision in the state. As a result, counties in Hawaii provide some services, such as fire and police protection, that in other states are performed by cities or towns. Counties also elect a mayor and council. Likewise, the state government is responsible for functions usually performed by counties or cities in other states. Hawaii is the only state, for example, with a single unified public school system.

Approximately 71% of the state population resides in the City and County of Honolulu on the island of O'ahu, concentrated in the Honolulu metropolitan area. The neighbor island counties are Hawaii, Kaua'i (includes Ni'ihau) and Maui (includes Moloka'i, Lana'i, and Kaho'olawe, the latter is unpopulated).

Only 10% of the state's total land area is classified as urban. The City and County of Honolulu is the most urbanized with a third of its land area and 96% of its population in urban communities. The majority of tertiary health care facilities, specialty and subspecialty services are located on O'ahu. Consequently, neighbor island and rural O'ahu 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 Kaua'i. 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//

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 to 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//

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//

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//

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 throughout the state continued to be 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//

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 in compliance 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 \$20 permit from the state Department of Taxation by March 2007. Sets criminal penalties and forfeiture for retailers who sell tobacco without a permit. Will assist in monitoring of tobacco retailers, 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.

School lunch prices

Authorized the state Department of Education to adjust the price of school lunch to cover up to half the total cost of operating the program.

Minimum Wage

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

Pseudoephedrine

Sets a limit of 3 packages or 9 grams on any single purchase of products with the ingredient, which can be used to make "ice." Requires stores to keep the products behind the counter, in plain view of clerks, or within the scope of security cameras.

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.

Affordable housing

Omnibus bill gives greater flexibility for developers seeking rental housing loans and grants; establishes a general excise tax exemption for developers who set aside half their units as affordable; gives priority over rental housing funds to those developers who provide units for those families making 80% or less of median family income.

/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-compliance 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.

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.

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//

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 SSSS601 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//

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 of 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//

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//

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 enrollees, 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//

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//

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//

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//

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//

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//

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 public 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//

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//

MATERNAL AND CHILD HEALTH BRANCH (MCHB)

The Maternal and Child Health Branch, comprised of 69 FTEs, works to promote and protect the health and well-being of mothers, infants, children and their families in the context of their communities. Eighteen of these positions are Title V funded, 20 state-funded and 31 funded by other federal sources. The branch is divided into four program sections: Perinatal Support Services, Children and Youth Health Services, Family Planning Services and Family Support Services. MCHB contracts for many direct, enabling and population based services through a collaborative network of non-profit and private providers. The Branch program staff concentrates primarily on core public health services like assurance activities through contract monitoring; systems development through mobilizing community partnerships and coalitions; monitoring of health status, service delivery and utilization; and developing strategies to improve health status. The Branch continues to support a broad mandate with a limited infrastructure.

/2007/ This is the current description of the MCH Branch which was inadvertently omitted in last year's report.

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. //2007//

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//

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//

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

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

HAWAII COUNTY

The FHSD Neighbor Island Coordinator 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//

//2009/ 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 'Oiwī. Maternal and Child Support Services (MCSS) staff continue to be actively involved in 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.//2009//

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 Oihi, Keaau Family Health Center, Mobile Dental Van Project, and community volunteers. //2008//

MAUI COUNTY (Includes islands Maui, Moloka'i & Lana'i)

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 February 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//

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//

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// 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. The number of neighbor island direct service staff have been reduced because service provision is being contracted to private providers. //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.P.H. 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//

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//

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.

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.

/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//

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.

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//

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 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.

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//

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 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//

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//

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.

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 March 2008 ECCS Partnership Conference, the Hawaii's ECCS project supported attendance by a team of early childhood partners including the ECCS Coordinator, ECCS 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, building on strong collaborative relationships that have developed over the years, 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 evidence-based programs with which Hawaii was involved (Center on the Social Emotional Foundations for Early Learning, Zero to Three, Strengthening Families National Network, and Healthy Start). //2009//

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/ Title V is involved in a newly formed Suicide Prevention Steering Committee.

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//

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.

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.

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 (HYH) a statewide coalition of leaders sharing a concern about teen pregnancy. The HYH mission is to create networks and promote effective programs for Hawaii's youth that support healthy and informed choices. A primary goal is to promote the use of science/evidence-based sexual health education programs that are culturally appropriate to prevent teen pregnancy, STIs and HIV among 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.

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.

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 most Title V infant measures 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	2003	2004	2005	2006	2007
Annual Indicator	35.8	32.5	27.0	25.4	20.4
Numerator	302	284	209	207	177
Denominator	84356	87433	77324	81476	86690
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.

Notes - 2005

Asthma defined by primary ICD9 codes 493.xx. Hawai'i residents only. Data is by calendar year. Data for the year 2004 was revised with a hospitalization data file. Data for the year 2005 is based on a provisional hospitalization data file. Population data based on U.S. Bureau of the

Census, Population Estimates Program, SC-EST2005-AGESEX_RES: Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2005., released August 4, 2006.

Narrative:

Data for this measure comes from the Hawaii Health Information Corporation (HHIC) a private, not-for-profit corporation established in 1994 to collect inpatient discharge records from Hawaii's 22 acute care hospitals for each year since 1993. The rate excludes newborns, pregnancy-related admissions and patients admitted through a transfer from another facility. The denominators are from 2006 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 24-2 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 the Hawaii's Comprehensive State Asthma Surveillance System (CSASS) to measure and track the asthma burden through 4 key indicators: (1) asthma prevalence, (2) asthma severity, (3) asthma management, and (4) asthma cost. Over the years, the HSACP has published and disseminated two comprehensive reports: (1) State of Asthma - Hawaii 2004 Burden Report, and (2) State of Asthma - Hawaii 2006 Supplement documenting current and lifetime prevalence of asthma, emergency department visits, hospitalizations, health status, health/lifestyle behavior, and mortality.

Approximately, 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 also estimates that about 19.4 % or 58,900 children living in Hawaii reported having asthma at some point 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 through the 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 over the years that are willing to commit their professional expertise and resources towards the implementation of activities outlined in the Hawaii Asthma Plan: A Strategic Plan for Addressing Asthma in Hawaii 2006 -- 2010 (HAP).

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

To address asthma from a public health perspective, the HSACP will continue to focus its efforts in 2007-2008 on the following three main content areas: (1) surveillance, (2) partnerships, and (3) interventions. The following content areas continue to be driven by an explicit set of guiding principles outlined in the HAP.

/2009/ On March 2008, a new volcanic vent opened on Hawaii island's Kilauea volcano which has been quietly erupting since 1983. The new vent resulted in drastically higher levels of volcanic smog (referred to as "vog"). Before the new vent opened, the volcanic summit emitted 200 tons of sulfur dioxide per day, but now the crater releases about 2,000 tons per day. While most of the vog is blown out to sea with regular tradewinds, seasonal weather conditions have kept the vog lingering over Hawaii island for a number of days and created 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 seasonal warm southeasterly winds. While the short-term exposure to vog can trigger asthma symptoms for those with the condition, several research studies have shown exposure to vog is not responsible for the 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//

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	2003	2004	2005	2006	2007
Annual Indicator	84.2	85.2	87.1	87.4	87.4
Numerator	6405	6925	7141	6960	6960
Denominator	7606	8131	8201	7961	7961
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.

Notes - 2005

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 2005 is not available at this time. Historically, Hawaii has had a high percentage of Medicaid enrollees under the age of one year receiving at least one initial EPSDT periodic screen.

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//

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	2003	2004	2005	2006	2007
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 - 2007

Since SCHIP is a Medicaid 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 Medicaid agency will be able to provide this information in the future. Title V will continue to request this information.

Notes - 2006

Since SCHIP is a Medicaid 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 Medicaid agency will be able to provide this information in the future. Title V will continue to request this information.

Notes - 2005

Since SCHIP is a Medicaid expansion program in Hawaii, separate service utilization data is not available for SCHIP enrollees at this time. Thus, data for FY 2001-2005 are estimates. 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. Information for FY 2005 was not available to complete an estimate for the indicator, thus data for 2003 was used.

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 2009, 18,717 children were enrolled in the SCHIP program.//2009//

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	2003	2004	2005	2006	2007
Annual Indicator	69.3	67.3	66.7	65.9	67.7
Numerator	12488	12244	11897	12436	12877
Denominator	18013	18186	17829	18873	19010
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.

Notes - 2005

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:

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 qualify 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//

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	2003	2004	2005	2006	2007
Annual Indicator	43.9	67.3	71.7	72.3	72.3
Numerator	48526	81758	90273	91323	91323
Denominator	110459	121477	125902	126344	126344
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

Notes - 2005

This is a new Health Systems Capacity Indicator added in for the five-year report period, FY 2006-2010.

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). The denominator is made up primarily of DHS data as HHS numbers are below 4,000 children each year.

Medicaid data was not available in time for this report, thus the indicator for 2004 is repeated for 2005. The fiscal year 2003 and 2004 data do not appear accurate when compared to fiscal year 2000-2002 data. The Title V program met with the data staff at the Medicaid agency to discuss concerns about the 2003 data. Although more accurate data was expected for 2004, data problems continue. The Title V program will continue to meet with staff at the Medicaid agency to address data issues.

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 available 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//

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	2003	2004	2005	2006	2007
Annual Indicator	52.5	43.1	54.0	53.3	53.3
Numerator	11343	10069	12998	12933	12933
Denominator	21617	23378	24060	24262	24262
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

Notes - 2005

Data for this measure is from the Centers for Medicare and Medicaid Services (CMS) report form HCFA-416, Annual EPSDT Participation Report.

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//

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	2003	2004	2005	2006	2007
Annual Indicator	31.4	30.2	24.6	26.1	34.4
Numerator	376	378	324	352	477
Denominator	1199	1250	1317	1350	1387
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

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.

Notes - 2005

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 2005", Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100% data. The table was sent to CSHNB 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//

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2007	other	8	8	8

Notes - 2009

Currently, there are no linkages between birth certificate data files and Medicaid data files. The SSDI Project staff and the Title V Director facilitated a verbal agreement with the Medicaid Director to conduct a pilot project to link selected data elements. However, there are problems staffing the Medicaid Director's position. This will delay the linkage project until a new Director is appointed.

Data were obtained from hospital discharge records acquired from the Hawaii Health Information Corporation (HHIC)-a private, non-profit corporation that maintains a database of health care encounters in the State. Hospital discharge data reflects the actual insurance or lack of insurance that was billed for the delivery. Cases of unknown or missing insurance were excluded from the "non-Medicaid" category but included in the "All" category. Infants with birth weights that were missing or <500 grams were excluded from calculations.

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) data server was not successful due to payment and procurement issues.

Thus, the Title V agency purchased an extracted dataset with infant delivery and death information 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), began discussions 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 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 pursue discussions again with Medicaid 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. //2009//

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2007	other	8	5.9	6.7

Notes - 2009

Currently, there are no linkages between birth certificate data files and Medicaid data files. The SSDI Project staff and the Title V Director facilitated a verbal agreement with the Medicaid Director to conduct a pilot project to link selected data elements. However, there are problems staffing the Medicaid Director's position. This will delay the linkage project until a new Director is appointed.

Data were obtained from hospital discharge records acquired from the Hawaii Health Information Corporation (HHIC)-a private, non-profit corporation that maintains a database of health care encounters in the State. Hospital discharge data reflects the actual insurance or lack of insurance that was billed for the delivery. Cases of unknown or missing insurance were excluded from the "non-Medicaid" category but included in the "All" category. Rates are three year averages calculated by dividing the number of births by the total infant deaths during the period 2003 to 2005 according to insurance (period rather than cohort method).

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//

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

INDICATOR #05 <i>Comparison of health</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-	ALL

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				MEDICAID	
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	other	67.9	85.5	80.1

Notes - 2009

Currently, there are no linkages between birth certificate data files and Medicaid data files. The SSDI Project staff and the Title V Director facilitated a verbal agreement with the Medicaid Director to conduct a pilot project to link selected data elements. However, there are problems staffing the Medicaid Director's position. This will delay the linkage project until a new Director is appointed.

Estimates come from the 2006 Hawaii PRAMS. Insurance status was determined by a self-reported measure on the survey on how the delivery was paid for. Cases of unknown or missing insurance were excluded from the "non-Medicaid" category but included in the "All" category. In the future, hospital discharge data may be linked to the birth certificate so that figures will be based on the full population of women who deliver live births rather than a sample.

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//

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 indicators for Medicaid, non-Medicaid, and all MCH populations in the State	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is	2007	other	59.1	69.4	65.9

greater than or equal to 80% [Kotelchuck Index]					
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Notes - 2009

Currently, there are no linkages between birth certificate data files and Medicaid data files. The SSDI Project staff and the Title V Director facilitated a verbal agreement with the Medicaid Director to conduct a pilot project to link selected data elements. However, there are problems staffing the Medicaid Director's position. This will delay the linkage project until a new Director is appointed.

Estimates come from the 2006 Hawaii PRAMS. Insurance status was determined by a self-reported measure on the survey on how the delivery was paid for. Cases of unknown or missing insurance were excluded from the "non-Medicaid" category but included in the "All" category. In the future, hospital discharge data may be linked to the birth certificate so that figures will be based on the full population of women who deliver live births rather than a sample.

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//

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)	2007	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)	2007	300

Notes - 2009

Hawaii's SCHIP Program is a Medicaid expansion with a ceiling of 300% Federal Poverty Level (FPL) for all age groups. Hawaii'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:

In Hawaii the Department of Human Services (DHS) is the Medicaid agency. Hawaii's SCHIP Program is a Medicaid 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 date of January 2008, however, DHS will need to secure permission from CMS to amend eligibility requirements 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//

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)	2007	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 women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 5) (Age range 6 to 14) (Age range 15 to 18)	2007	300 300 300

Notes - 2009

Hawaii's SCHIP Program is a Medicaid expansion with a ceiling of 300% Federal Poverty Level (FPL) for all age groups. Hawaii'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:

See narrative for HSCI 6a.
 //2009/ No change in eligibility.//2009//

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	2007	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	2007	

Notes - 2009

Hawaii's SCHIP Program is a Medicaid expansion with a ceiling of 300% Federal Poverty Level (FPL) for all age groups. Hawaii'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//

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	3	Yes

Annual linkage of infant birth and infant death certificates		
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
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	2	No
Annual birth defects surveillance system	3	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

In 2007, the Women, Infants and Children (WIC) Services Branch entered into an agreement with the Office of Health Status Monitoring (OHSM) to link birth records with WIC clinical data. Initially, this linkage is with WIC's annual data for years 2003 to 2007. Thereafter, data will be submitted on a quarterly basis. WIC Services Branch essentially submits data of infants born within the reporting period to OHSM, who in turn, returns the birth mother demographic data and the link and Hi Track numbers for Children with Special Needs Branch (CSHNB) data. This linkage establishes the mother-child relationship in the WIC data and potential linkage with CSHNB.

In 2004, Children with Special Health Needs Branch (CSHNB) reach an agreement with our vital statistics office, Office of Health Status Monitoring (OHSM), to link birth records with our Newborn screening programs data. This linkage is done on an annual basis. CSHNB provides OHSM a dataset consisting of records from our linked Newborn Hearing Screening Program (NHSP) and Newborn Metabolic Screening Program (NMSP). This linkage is done at OHSM which sends the linked dataset back to CSHNB along with selected demographic variables. Data from the 2003 shows a 99.5 % linkage rate. WIC reach an agreement with our vital statistics office, Office of Health Status Monitoring (OHSM), to link birth records with WIC program data. One year of data has been linked thus far, but it is planned to have linkage done on an annual basis.

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 databases and indicated that 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 22 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 with virtually full 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 Attorney General'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 by the program 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 discharge data see HSCI 5a.

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

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)	2	No

Notes - 2009

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 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//

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//

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	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	12	9	10	11	13
Denominator	12	9	10	11	13
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
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2007

Data is from the State Newborn Metabolic Screening Program, Department of Health. Since September 2003 Hawai'i tests for 31 disorders.

Notes - 2006

Data is from the State Newborn Metabolic Screening Program, Department of Health. Since September 2003 the State of Hawaii tests for 31 disorders.

Notes - 2005

Data is from the State Newborn Metabolic Screening Program, Department of Health. Since September 2003 the State of Hawaii tests for 31 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 2007 objective was met.

Hawaii's newborn screening testing laboratory, the Oregon State Public Health Laboratory (OSPHL), started screening for cystic fibrosis (CF) for Hawaii's infants on September 1, 2007, following successful contract negotiations. NBMSPP 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. NBMSPP developed informational flyers on cystic fibrosis; revised the newborn screening parent brochure; and disseminated these statewide to health providers. 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 (ACMG) and the March of Dimes (MOD) for a uniform panel of 29 disorders across all states.

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

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 (DOH) website.

Because NBMSPP 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, NBMSPP has been giving newborn screening specimen collection kits to midwives and naturopaths without charge.

NBMSPP participated in the Genetics Program's HRSA funded Sickle Cell Grant by working on the Sickle Cell and Alpha Thalassemia protocols and guidelines. Once these are finalized, they will be distributed to health practitioners throughout the state.

NBMSPP 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. A meeting was held in Portland on September 26-28, 2007 to get updates on WSGSC activities in

each of the states and territory , as well as to get updates on such activities as transition to adulthood; family to family information centers; genetic services outcomes; working with the medical home; and the practice model using telemedicine and outreach clinics. Project funding is from the Health Resources and Services Administration, Maternal and Child Health (MCH) Bureau, Genetic Services Branch.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Add state mandated screening for cystic fibrosis.			X	X
2. Contract for central laboratory testing.			X	X
3. Contract for transport of specimens to central 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. Five infants were diagnosed with organic acid disorders and four infants with fatty acid oxidation disorders through expanded tandem mass screening. The overall newborn screening false positive rates for the additional amino acid, urea cycle, fatty acid oxidation, and organic acid disorders continue to be low.

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 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.

The following activities will need to be accomplished to fully implement CF screening for Hawaii's infants: amend the newborn screening Hawaii Administrative Rules, conduct public hearings, and have the revised administrative rules signed into law; increase newborn screening fees from \$47 to \$55 per initial newborn screening kit; add a nurse position to NBMSP to assist with short and long-term follow-up; revise the Newborn Screening Practitioner's Manual; and provide more statewide educational sessions.

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.

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	2003	2004	2005	2006	2007
Annual Performance Objective	52.4	52.4	52.4	52.4	52.5
Annual Indicator	52.4	52.4	52.4	52.4	59.3

Numerator	10114	10114	10114	10114	20783
Denominator	19291	19291	19291	19291	35041
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
	2008	2009	2010	2011	2012
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.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

The 2005 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

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.

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, implemented the Hilopa'a Project-Integrated Systems for CSHCN. The project aims to improve access for CSHCN and their families to quality, comprehensive, coordinated, and community-based systems of services, using an integrated approach in addressing the six core outcomes for CSHCN.

Early Intervention Section (EIS), with Early Childhood Outcomes Center and UH Center on Disability Studies, developed a measurement system reflecting Part C early intervention (EI) goals. EIS developed a set of goals/indicators and is building the capacity to collect, report, and use data for program improvement. Goals for families include 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.

Hilopa'a Project worked to increase family participation in program and policy activities. A family and youth survey was developed to identify areas of interest and participation. Guidelines on Compensation for Family Participation were developed, implemented, disseminated to other programs as sample, and placed 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 participates on the QUEST Advisory Council.

The Hilopa'a Project's Convergence 2006 conference focused on developing family leaders and family-professional partnerships in program and policy activities. More than 120 families, professionals, self advocates, state staff and neighbor island representatives attended. National leaders were Dr. Rich Antonelli and Patti Hackett from Healthy and Ready to Work National Center. Family-professional teams held discussions on QUEST changes, Medicaid waivers, successful parent-child-physician partnerships, transition from early intervention and after high school, and teams working well in challenging situations.

Natural supports workshops with families and professional partners were provided at Family Convergence 2006, Hawaii Families as Allies, and Family Support 360 conferences.

MCH LEND trainees and faculty and Hilopa'a Project staff convened 9 focus groups with family members and self-advocates on the conversion of Medicaid Aged, Blind, and Disabled (ABD) beneficiaries from fee-for-service to managed care. The responses helped to shape the development of outreach and informational materials on changes in health coverage and health plan selection to the ABD population.

The Hilopa'a 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 provides information and referral, consultation, and training to families of CSHCN and their professional partners statewide.

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

Families participate in various ways, including as council, task force, and advisory committee members; reviewing parent education materials; presentations at conferences; and legislative advocacy.

The Hilopa'a F2FHIC has been established with two "veteran moms" providing family to family support and information. It has local numbers on all neighbor islands, which are centrally connected. The F2FHIC also provides trainings, in partnership with the Hilopa'a Project.

The Hilopa'a 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.

Hawaii's Title V Family Trainers Academy is a new initiative of the Hawaii MCH LEND Program, Hilopa'a Project, and Hilopa'a F2FHIC. This summer institute focuses on developing community based trainers to serve families, their professional partners and the local Community Children's Councils. The course work includes 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 are from all islands and include parents, self-advocates, and a youth self-advocate.

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.

The Hilopa'a Project and Hilopa'a F2FHIC will continue to provide trainings on Natural Supports and Transition for families and professional partners. The Rainbow Book training will be updated to include new QUEST information.

The Hilopa'a F2FHIC 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.

A bill passed by the 2008 Legislature establishes an Autism Spectrum Disorders (ASD) Benefits and Coverage Task Force to research the problems faced by parents of children with ASD and what can be done to ensure that proper benefits and services are provided through public and private resources to address the needs of children with ASD. CSHNB is responsible for the facilitation and research for the Task Force. Three members of the task force will represent organizations representing children with ASD.

The Title V Needs Assessment for CSHCN, to be done in 2009, will include input from families of CSHCN.

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 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	2003	2004	2005	2006	2007
Annual Performance Objective	47.9	47.9	47.9	47.9	47.9
Annual Indicator	47.9	47.9	47.9	47.9	45.2
Numerator	14657	14657	14657	14657	15632
Denominator	30627	30627	30627	30627	34568
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
	2008	2009	2010	2011	2012
Annual Performance Objective	45.2	45.2	45.2	45.2	45.2

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.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

The 2005 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

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 in Hawaii.

CSHNB and Family Voices of Hawaii, with AAP-Hawaii Chapter and UH Department of Pediatrics, implemented a Hilopa'a Project-Integrated Systems for Children with Special Health Care Needs (CSHCN). The project focuses on improving access for CSHCN and their families to comprehensive, coordinated, and community-based systems of services, and addressing the six core outcomes for CSHCN, including medical home.

The Hilopa'a Project supported 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 have included Medical Home Noon Conferences with facilitators and parent representatives responding to the pediatric residents' best practice examples, and orientation to the Rainbow Book with case studies on appropriate referrals to community services.

CSHNB programs incorporate 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.

For the Early Childhood Comprehensive System (ECCS) Plan, CSHNB, MCH Branch, AAP-Hawaii Chapter, UH Department of Pediatrics, and Medical Home Project representatives contributed to the medical home and developmental screening goals and objectives. The ECCS Plan 2005-2008 included two medical home goals--"Family-centered care and family/professional partnerships will be key elements of medical homes" and "Developmental surveillance, periodic screening, and follow-up for children ages 0-5 years will be improved."

Hilopa'a Project promotes 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 MCH Branch provided ASQ training for community health centers, community physicians, and their office staff.

The AAP-Hawaii Chapter adopted a position statement that the Chapter will 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 included PEDS and ASQ.

DHS Med-QUEST Division revised its EPSDT Guidelines in July 2007, with assistance from the EPSDT Advisory Council, UH Department of Pediatrics, and Hilopa'a Project. The guidelines include PEDS/ASQ developmental screening for children age 9 months to 5 years, and hearing, vision, dental/oral, and development/behavior surveillance at all visits.

The 2006 Legislature adopted a concurrent resolution (SCR 70 HD1) establishing a Hawaii Childhood Screening Task Force. CSHNB, with Hilopa'a 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.

Children with Special Health Needs Program (CSHNP) supports the medical home 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.

CSHNB/CSHNP, UH Department of Pediatrics, and Kapiolani Medical Center representatives began planning a pilot clinic for young children with cleft lip/palate identified through the Neonatal Intensive Care Unit.

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, & 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.				
10.				

b. Current Activities

Training on the Modified Checklist for Autism in Toddlers (M-CHAT) for pediatricians was provided at an AAP-Hawaii Chapter meeting in February 2008. A team of a parent of a child with autism spectrum disorder and child psychiatrist conducted the training, with Hilopa'a Project support.

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 professionals from various agencies, family members, and self advocates on all islands. The Project continues PEDS and ASQ developmental screening trainings for pediatricians and family physicians. The Preschool Developmental Screening Program is now assisting with ASQ training.

The Screening Task Force report to the 2008 legislature, drafted by CSHNB, identified areas for further action, including improving vision and hearing screening for preschool/school-aged 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.

Working with CSHNP, the UH Department of Pediatrics and Kapiolani Medical Center established a new multidisciplinary Oral Cleft Clinic. 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 Oral Cleft clinic. Plans are now being developed to fill the gap when a plastic surgeon/craniofacial specialist leaves Hawaii. The clinic provides coordinated, comprehensive services for children with craniofacial disorders with complex medical needs, who would otherwise receive services in multiple provider offices in the community.

CSHNB and other ECCS partners will continue work toward achieving the Hawaii ECCS Plan 2005-2008 outcome that all children will have access to and receive preventive and ongoing regular care.

AAP-Hawaii Chapter has convened a Pediatric Council which includes Medical Directors of various health plans. A future Council meeting will focus on developmental screening.

The Hilopa'a Project has been extended to April 2009. Activities to be continued include medical home training with pediatric residents, Rainbow Book training, and developmental screening training.

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 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.

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 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	2003	2004	2005	2006	2007
Annual Performance Objective	70.2	70.2	70.2	70.2	70.2
Annual Indicator	70.2	70.2	70.2	70.2	73.5
Numerator	21980	21980	21980	21980	26078
Denominator	31318	31318	31318	31318	35459
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
	2008	2009	2010	2011	2012
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.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

The 2005 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

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.

Early Intervention Section (EIS), with Healthy Start and Public Health Nursing Branch, provide 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. It collaborates with federal, state, and community agencies, conducts outreach activities and helps Med-QUEST simplify its processes.

In October 2006, DHS increased QUEST eligibility up to 250% of the federal poverty level,

reduced monthly premiums for children of families with income above 250% FPL (QUEST-Net), and continued direct payments to hospitals to defray the costs of treating uninsured patients.

DHS continued planning to revise the Medicaid/QUEST program to include enrolling the Aged, Blind, and Disabled (ABD) population into managed care plans. QUEST Expanded Access (QExA) Advisory Committee and advocacy community worked on preparatory activities to make the transition easier for new health plans and the ABD population.

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.

MCH Leadership in Education in Neurodevelopmental and Related Disabilities Program (MCH LEND) trainees/faculty and Hilopa'a Project staff convened 9 focus groups with family members and self-advocates on the conversion of Medicaid ABD beneficiaries from fee-for-service to managed care. The responses helped to shape the development of outreach and informational materials on changes in health coverage and health plan selection.

DHS Med-QUEST Division revised its EPSDT Guidelines in July 2007, with assistance from the EPSDT Advisory Council, UH Department of Pediatrics, and Hilopa'a Project. The guidelines include periodic PEDS/ASQ developmental screening for children age 9 months to 5 years, in addition to hearing, vision, dental/oral, and development/behavior surveillance.

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 coverage or services when family needs are not met.				X
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

CSHNP care coordinators/program staff provide information, assist CSHCN/families in obtaining health coverage, and assist with benefits/resources as needed.

DHS raised QUEST and Medicaid fee-for-service income eligibility levels up to 300% FPL. Premium payments for children in households between 251-300% FPL were eliminated.

Keiki Care is a new program developed by Hawaii Medical Service Association and the State to provide health care coverage for uninsured children age 31 days through 18 years, who are not eligible for other state or federal coverage. It provides only basic health care benefits, including physician visits, immunizations, certain preventive services, diagnostic tests, emergency care, mental health benefits, and limited prescription drug coverage.

DHS issued its Request for Proposal for QExA managed care plans to cover eligible individuals who are 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 are projected to begin November 2008.

The Hilopa'a Project provides trainings on the "Rainbow Book--A Medical Home Guide to Resources for CSHCN and Their Families", which includes Medicaid/QUEST, Supplemental Security Income (SSI), and TRICARE for military families. Trainings are for professionals from various agencies, family members, and self advocates on all islands.

c. Plan for the Coming Year

CSHNB programs will continue to provide direct and enabling services as a safety net and to increase access to services, especially 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.

The QExA managed care plans are expected to begin November 2008. CSHNB staff will provide information about QExA to families as needed.

The Hilopa'a Project has been extended to April 2009. The Rainbow Book training will continue, with supplemental training to include a QUEST/Medicaid update. The Project will continue to assist DHS as needed to regarding outreach or information to families.

AAP-Hawaii Chapter has convened a Pediatric Council which includes Medical Directors of various health plans. A Council meeting focusing on developmental screening is planned

A bill passed by the 2008 Legislature establishes an Autism Spectrum Disorders (ASD) Benefits and Coverage Task Force to research the problems faced by parents of children with ASD and what can be done to ensure that proper benefits and services are provided through public and private resources to address the needs of children with ASD. CSHNB is responsible for the facilitation and research for this Task Force.

Family Health Services Division, CSHNB, and EIS will examine approaches regarding health insurance coverage for early intervention services, as a possible way to increase other funding sources for early intervention services.

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	2003	2004	2005	2006	2007
Annual Performance Objective	69.2	69.2	69.2	69.2	69.2
Annual Indicator	69.2	69.2	69.2	69.2	88.8
Numerator	13319	13319	13319	13319	31708
Denominator	19257	19257	19257	19257	35713
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
	2008	2009	2010	2011	2012
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.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

The 2005 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

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.

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) convened 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.

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				X

Health.				
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. 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.

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. The training is presented by a pediatric geneticist and includes the impact of prenatal alcohol exposure on pregnancy outcomes, identifying and diagnosing of FASD, and outcomes for affected individuals.

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

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.

Hilopa'a Project will continue to provide Rainbow Book training/certification for programs, agencies, and providers on best practices for referral and transition for state/community programs. Project funding has been extended to April 2009.

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.

The 2008 Legislature established an Autism Spectrum Disorders (ASD) Benefits and Coverage Task Force to research problems faced by parents of children with ASD and approaches to ensure proper benefits and services through public/private resources. CSHNB will facilitate the Task Force. Hawaii data from the National Survey of CSHCN show a substantial need to improve the systems of services for children and youth with ASD in areas of family-professional partnership, medical home, community-based service systems easy to use, and transition to adult life.

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 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	2003	2004	2005	2006	2007
Annual Performance Objective	5.1	5.1	5.1	5.1	5.1
Annual Indicator	5.1	5.1	5.1	5.1	39.4
Numerator	351	351	351	351	5024
Denominator	6937	6937	6937	6937	12766
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
	2008	2009	2010	2011	2012
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.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

The 2005 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

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) provided training on transdisciplinary services, teaming, and transition to staff, Department of Education (DOE) Preschool Special Education and Student Support Coordinators, Head Start, Healthy Start, public health nurses, community preschools, and family members. EIS staff provided transition planning and support for children with developmental delays exiting from Part C early intervention (EI) services. EIS addressed the provision of timely transition activities, including Transition Plans, Transition Conferences, and Transition Notices, to be in compliance with requirements of Part C of the Individuals with Disability Education Act (IDEA).

Sequenced Transitioning in Education in Public Schools (STEPS) highlighted recommended practices in transitioning young children to preschool/kindergarten in the 2007 Hawaii Keiki Transition Conference.

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.

The 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 conference on Independent Living. The Department of Human Services (DHS)/Independent Living Program teaches foster youth to develop skills/knowledge to function independently.

The 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.

The Hawaii 360 Family Support Project designed and implemented a Navigational One Stop System for youth age 14-21 years with a developmental disability transitioning to adulthood. Using a combination of people and technology, the partner agencies and non-profits formed a seamless delivery system. 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 and referral for community services. A Neurotrauma Advisory Board subcommittee is assisting with marketing the Help Line. A bus placard was produced. A flyer developed for pharmacies, physician offices, and churches, will also be translated into different languages. The subcommittee is also working on a neurotrauma resource guide.

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. The 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 Children and Youth with Special Health Care Needs (CSHCN). The Project supports the "little transitions along the way toward achieving the Transition to adult life", as families at different stages gain knowledge to enhance decision-making, empowerment, and build the foundation for their child/youth's Transition to adult life. Activities include developing and providing training on the Rainbow Book with information on state/community resources, development of a Transition Planning Workbook and training for families and service coordinators, providing information on transition at family/professional conferences, and discussion of 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 services/projects in community.				X
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

Act 289 of the 2007 Hawaii State Legislature established the Hawaii 3-5 Transition Task Force to study the feasibility of expanding the DOH/EIS to include services for children ages 3-5 years. In Oct.-Nov. 2007, families of children in DOE preschool special education were surveyed. The survey showed that most families felt positively about their EI, DOE preschool, and transition experiences, and most families 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.

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 provides clarity to needs of the family and services being provided. Transition planning will be integrated into the ISP. Tools (based on the Hilopa'a Transition Planning Workbook) have been developed to foster discussion and to assist with data collection. Increasing staff knowledge regarding transition issues is ongoing via training.

See also State Performance Measure #9.

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. CSHNB will continue as a member of this Council.

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.

Hilopa'a Project will continue activities including trainings on Rainbow Book resources which include transition, and Transition Planning Workbook.

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	2003	2004	2005	2006	2007
Annual Performance Objective	77.2	77.9	78.3	78.6	84.8
Annual Indicator	79.1	81.2	80.1	80.1	83.7
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	86.6	88.3	90	91.7	92.4

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 calendar year reporting periods.

Notes - 2005

Data from 1999 reports on immunization series 4:3:1:3:3. Data comes from the U.S. National Immunization Survey, 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. 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 calendar year reporting periods.

a. Last Year's Accomplishments

Provisional data from the National Immunization Survey (NIS) indicate 83.7 % of children ages 19-35 months have completed the recommended schedule of immunizations in Hawaii in 2007. The state objective was not met, however, the Healthy People 2010 national objective of 80% was reached.

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

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 continues outreach efforts to enroll uninsured children into Med-QUEST.

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

Analysis from HIP's retrospective study of immunization records for all kindergarteners entering school in 2002 has been completed and was accepted for publication in Pediatrics Electronic Pages and posted on its web site in September 2007. The results should help delineate patterns of under-immunization by location and socio-demographic characteristics.

Statewide, population-based services focused on increasing public awareness and include 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 ages 0, 4, 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.

WIC and HIP collaborated on an incentive project to increase immunization rates in WIC service areas with the low immunization rates (targeting parts of Oahu, Maui and Hawaii Island). Parents received incentives for bringing in an up-to-date immunization record for their child, and again when the child completed the 4th DTaP vaccine. The results of the project showed that incentives had a significant effect in motivating parents to bring their child's immunization record to the WIC visits. However, its effect on improving immunization rates was not conclusive.

HIP convened a coalition of stakeholders, including health plans, community health centers and private physicians to assist with the development of an immunization registry. The coalition developed a description of functions and a timeline. Based on this work, HIP developed the Request for Proposals to procure the software, training, support and maintenance of the registry. HIP managed the registry coalition activities, including distribution of quarterly updates to members, facilitation of subcommittee meetings, and coordination of the annual meeting.

HIP worked to protect the health of infants by increasing access to immunizations for women of reproductive age. To decrease the risk of transmission in a high risk population, HIP collaborated with the STD/AIDS Prevention Branch and Title V's Family Planning program (FFP) to distribute free hepatitis B vaccine for women up to 42 years of age and their partners. Between 2006 and 2007, approximately 5,165 doses of Hepatitis B vaccine were given.

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

Ongoing direct, enabling, and population-based immunization services described in the previous narrative continue to be offered.

As part of its population-based services, Title V staff, as a member of the Hawaii Immunization Coalition's Infant Team, continues to meet regularly to plan outreach and provide information for the education of health professionals, community agencies, and DOH MCH Branch programs and partners.

HIP and the immunization registry coalition continue to work to establish the Immunization Registry. In December, 2007, HIP procured a statewide web-based immunization information system through Electronic Data Systems Corporation. Work on the Hawaii Immunization Registry started in February, 2008, with plans to pilot test the registry at seven Oahu sites in September 2008. This system will facilitate tracking and identification of children who are out of compliance.

The Hawaii Chapter of the American Academy of Pediatrics and the EPSDT Advisory Committee participate as members of the provider network to promote immunization compliance.

c. Plan for the Coming Year

Provisional data for 2007 will be updated. Since the HP 2010 national objective has been met, the state objectives have been modified to meet 90% by 2010. Subsequent objectives were set to increase at the same increment annually.

Title V will continue to support services described in previous years. The Hawaii Covering Kids Program efforts will continue to provide enabling services targeting disparate families including immigrants, Native Hawaiians, and Pacific Islanders. 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, Healthy Start, 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 immunization registry coalition will continue to oversee the development of the statewide Immunization Registry. This effort directly contributes to 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.

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	2003	2004	2005	2006	2007
Annual Performance Objective	23.5	23	22.5	22	18.6
Annual Indicator	18.8	18.5	19.4	21.4	19.6
Numerator	444	440	466	519	471
Denominator	23643	23802	24061	24297	24091
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
	2008	2009	2010	2011	2012
Annual Performance Objective	18	17.5	17	16.5	16

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.

Notes - 2005

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. Population data based on U.S. Bureau of the Census, Population Estimates Program, SC-EST2005-AGESEX_RES: Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2005., released August 4, 2006.

a. Last Year's Accomplishments

The 2007 provisional data indicate a rate of 19.6 live births per 1,000 teenagers aged 15-17. The state objective was not met, however in 2005 (latest available U.S. data) the Hawaii teen birth rate of 19.4 was lower than the national rate of 21.4.

The Healthy People 2010 goal for this 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 achieve this 2010 objective. In 2006, there were 34.9 pregnancies per 1,000 females aged 15-17 years.

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 efforts/activities and to provide technical assistance/oversight for TANF funded non-school contracts.

TANF funds supported the Department of Education's (DOE) Peer Education Program (PEP) that trains teens in health-related subjects so they may serve as peer mentors for other youth; and the University of Hawaii Summer Institute that provides graduate level training courses on human sexuality education for teachers during the summer break.

In 2007, DHS released training materials for program providers and other interested parties, the "Performance Measures for Hawai'i Teen Pregnancy Prevention and Positive Youth Development Programs." DHS providers were trained by the Lewin Group to utilize logic models and a report template to capture program outputs and outcomes.

The Title V Adolescent Wellness program is the Abstinence Only Education (AOE) coordinator for the state. Due to the uncertainty of federal funding, the AOE service provider, the Boys and Girls Club of Hawaii (BGCH), terminated their contract in January 2007. BGCH utilizes a "Start Smart" curriculum that encourages healthy youth development. Following the extension of the federal AOE funding in August 2007, BGCH conducted statewide community surveys and community events on sexual abstinence.

The Catholic Charities Family Services (CCFS) is in year 3 of a 5-year federal Community Based Abstinence Education (CBAE) award. Their abstinence-only curriculum "Try Wait," targets 12-18 year old youth in the schools. DOE has reviewed their curriculum and determined that it does not support the Board of Education's Abstinence-Based Education Policy. The policy requires educators to present abstinence first, as the most effective method to avoid pregnancy/STIs, but must also provide students with comprehensive information on responsible/safe sex practices.

Maui Youth and Family Services (MYFS) was also a CBAE grantee but returned the grant back to the Administration for Children and Families (ACF) due to personnel and organizational changes.

The DOE HIV/STD resource teacher continued to train teachers using evidence-based sexual education curriculums including "Making a Difference" (MAD) and "Reducing the Risk" (RTR). In addition, Title X funds Family Planning Program (FPP) Health Educators who have been trained in MAD and RTR, and work collaboratively to support DOE health teachers.

The Title X funded FPP assured confidential family planning services for adolescents and also supported the Waikiki Health Center's Male Achievement Network (MAN) project through the

center's Youth Outreach Program. MAN staff provided educational counseling to male clients, including incarcerated youth, and those attending alternative schools for at risk youth.

A CDC Teen Pregnancy and STI Prevention Capacity Building Grant was awarded to Hawaii Youth Services Network (HYSN) to provide funds for staff support to the Hawaii Teen Pregnancy, Prevention and Parenting Council (HTPPPC), currently known as Healthy Youth Hawaii (HYH). HYSN also provided training programs utilizing science-based approaches to prevent teen pregnancy and sexually transmitted diseases.

Title V was a sponsor in the September 2007 two day conference, "Let's Talk About Sex", for clinical and community providers that work with teens and their families

The 2006 legislature passed a resolution requesting DOH convene a working group to determine family planning funding needs for legislative consideration in the state's fiscal 2007-2009 budget. The FP program convened a stakeholders group to begin the needs assessment work, including 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. Plan and administer Temporary Assistance to Needy Families funds for teen pregnancy prevention.				X
5. Contract for Abstinence Only Education Program to selected at-risk communities.		X	X	X
6. Contract for family planning educational outreach and clinical services.	X	X	X	X
7. Support the administration of the Youth Behavioral Risk Survey in High Schools and Middle Schools to collect student health data for program planning.				X
8. Provide training to adolescent service providers to encourage use of evidence based practices to improve the effectiveness of service delivery.				X
9.				
10.				

b. Current Activities

The 2007 Youth Risk Behavior Survey (YRBS) for high school students showed that 36.2% reported having sex at least once (similar to the 35.7% reported in 2005); 23.6% reported being currently sexually active (a slight decrease from 24.1% in 2005). Rates were lower than U.S. averages.

The Boys & Girls Club of Hawaii (BGCH) continues their abstinence education contract with DOH, after a brief suspension of program services.

DOE principals were notified that the CCFS Abstinence-Only curriculum "Try Wait!" is not in compliance with the DOE policy and cannot be used in public schools until the curriculum is changed to provide comprehensive information on contraceptives.

Healthy Youth Hawaii (HYH) was the lead agency in the May 2008 2nd annual Teen Pregnancy Prevention Month with a slogan/art contest that will be used in public informational materials. A website, radio promotion, and Governor's proclamation was also planned.

The 2007 \$1.7 million supplemental appropriation for Family Planning Program services was contracted to statewide FFP providers including community based educational outreach services for teen pregnancy prevention.

HYSN has broadened their scope beyond teen pregnancy prevention and transitioned HYH to address all adolescent health issues. The HYH membership of health educators receives training on evidence based practices to provide instruction to other service providers. The program helps build the infrastructure capacity within the state.

c. Plan for the Coming Year

Provisional data for this measure will be updated in next year's report. Hawaii objectives have been set to reduce teen births by 0.5 percentage point each year.

The 2007 YRBS data shows that Hawaii students are at less risk regarding sexual behaviors than the U.S. overall with the exception of condom utilization. The rate for this measure was roughly equal to that of the nation based on confidence intervals (Hawaii 45.8% vs. 38.5% national average).

Title V's effort to reduce teen pregnancy will continue in collaboration with state and community agencies to assure greater public awareness of the state's efforts to reduce unintentional pregnancy, and to assure adequate program funding and resources are available to reduce the teen birth rate. Title V will provide technical assistance to 10 new non-school based teen pregnancy prevention programs including two on the neighbor islands.

Healthy Mothers Healthy Babies, Planned Parenthood, Hawaii Youth Services Network (HYSN)/ Healthy Youth Hawaii (HYH), Hale Kipa and other stakeholders will partner with Title V to convene a Teen Pregnancy Awareness Summit for Hawaii's officials in FFY 2009.

Title V will collaborate with HYSN/HYH to provide technical assistance to TANF contractors to utilize Lewin evaluation techniques and support the use of evidence-based teen pregnancy and STD/HIV prevention programs.

Title V will update the state adolescent wellness plan. The plan serves as a resource guide to promote healthy youth development, including teen pregnancy prevention.

Title V neighbor island activities such as Malama Kauai, will continue to offer pregnancy testing, counseling, and referral services to teens at the Community College Wellness Center and DOH office. Kauai DOH will work with adult and teen Drug Court clients on family planning and STD education.

In addition, HYSN will provide technical assistance and training support to community stakeholders who will be collaborating and applying for two national teen pregnancy prevention grants.

The DOH FPP will continue to offer confidential family planning clinical services for adolescents 19 and younger. Supported by increased state funding, FPP health educators will expand outreach services to teens on the benefits of abstinence, delaying sexual intercourse, contraception options, and importance of consistent condom use.

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	2003	2004	2005	2006	2007
Annual Performance Objective	25	26	25	25	26
Annual Indicator	21.2	24.1	24.7	25.6	27.7
Numerator	533	725	782	886	824
Denominator	2517	3009	3171	3460	2971
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
	2008	2009	2010	2011	2012
Annual Performance Objective	26	27	27	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.

Notes - 2005

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 2007 school year, the indicator is 27.7 which meets the 2007 state objective of 26. Hawaii is slowly making progress to achieving the Healthy People 2010 goal of 50%.

The major stakeholders (private and public) are acutely aware that Hawaii 's children continue to have one of the highest rates of poor oral health in the nation despite relatively high dental insurance coverage, and strive to work together to improve the oral health of children in Hawaii.

Though the Hawaiian Islands Oral Health Task Force has completed its purpose, its members continue to develop steps toward the implementation of the plan. The Tri-County Oral Health Task Force, The Kauai Dental Health Task Force, The Hawai'i Island Dental Task Force, and the Maui Oral Health Task Force continue to meet separately to address the needs of their communities while assuring that the content areas and objectives mirror the Task Force's plan. The dental coalitions on the neighbor islands 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. Also 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.

Community-based safety net providers through state-funded primary care contracts, provide limited dental services on-site for the under and uninsured population to assure more comprehensive care. During the fiscal year 2007 period, statewide dental services for children (0-18 years) totaled 453 visits at 6 primary care health centers.

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

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

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

Statewide, the Medicaid-QUEST program provides dental services through a fee-for-service system that includes a strong case management component for those who have difficulty accessing dental services. Recognizing the importance of dental care for pregnant women in the prevention of caries formation in children, the Medicaid-QUEST program now provides limited dental coverage for qualifying women. Women are encouraged to access their dentists for check ups during pregnancy. An educational brochure to promote the \$500 credit for dental evaluation and cleaning for pregnant women is being developed for Perinatal and WIC providers. The Native Hawaiian Health Care community health center on Kauai continue to provide dental services. On Molokai, a Federally Qualified Health Center has been established. The health center has a dental clinic with a full time dentist and dental hygienist that fills a much needed

source of dental care for the community.

On the island of Hawaii, North Hawaii and West Hawaii continue to be served by 2 mobile dental units. They are able to hold 20 clinics per month in various locations.

DHD continues the process of developing a dental health curriculum to meet the school health standards so that dental education can be integrated into the public school health curriculum.

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.

c. Plan for the Coming Year

Title V will continue to support the DOH Dental Health Division to acquire current data for this measure and other child oral health indicators using federal State System Development Initiative (SSDI) grant funding. Based on the past 6 years of data, the objectives for this measure were revised to reflect more achievable progress toward the Healthy People 2010 objective of 50%. Although the state objective was met this year, objectives will not be revised until there is a clear trend showing continued progress. Indicators can often vary from year to year.

Title V will support the recommendations of the Hawaiian Islands Oral Health Task Force 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 under- and uninsured, especially in areas that are underserved.

Title V recognizes that good oral health for children begins with pregnant women and women of childbearing age. Efforts will be made to have oral health education included in all population-based programs for perinatal clients and advocate for dental care to be included in all health insurance coverage for pregnant women.

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 young families to ensure that each child, including those with special needs, has an appropriate dental home and is accessing routine care. The proper use, placement and monitoring of dental sealants would be one important aspect of this preventive, routine dental care.

Continuing collaboration among primary care and dental providers is the primary focus to improve the dental health of children in Hawaii. Moreover, most dental insurance plans in Hawaii cover sealant placement and the number of children with insurance is relatively high. The DHD will continue with their screenings, fluoride rinse and education programs in various schools. Funding to support DHD staff to screen neighbor island children is provided by the federal SSDI grant to ensure adequate statewide data collection.

Title V will convene key stakeholders to discuss implementing strategies to improve children's oral health identified through the Title V needs assessment process. Strategies identified include reinstating the policy for each child entering school to have a dental health certificate and establishing a curriculum to train health care professionals on the importance of children's oral health and provide helpful information to parents.

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	2003	2004	2005	2006	2007
Annual Performance Objective	3	2	3	2	1.4
Annual Indicator	2.2	1.9	2.0	2.7	2.7
Numerator	16	14	14	19	19
Denominator	741644	745237	706304	703917	703917
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
	2008	2009	2010	2011	2012
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.

Notes - 2005

Data is for resident population and is by calendar year. Data for the year 2004 was revised with an updated death data file. Data for the year 2005 is provisional. 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 2006-07 indicator is 2.7. The state objective was not met. The rates have stayed relatively stable over the past 5 years for this measure.

The numbers for this measure are so small for the State that the indicator may vary tremendously given 1 or 2 motor vehicle crashes. The actual number of crash-related deaths for this measure in 2006 was 7 (the numerator reported reflects a 3-year average).

Title V continued to partner with Keiki Injury Prevention Coalition (KIPC), DOH Injury Prevention and Control Program (IPCP) and the State Department of Transportation (DOT) Safe Communities Initiative to disseminate information and education on injury prevention issues through an extensive network of community agencies. KIPC trademarked the logo, "Drive Pono", for a new Teen Driver Safety campaign. The television public service announcements (PSAs) for the campaign were developed by teens.

Effective January 1, 2007 Hawaii became the 35th state to have a booster seat law which requires children between the ages of 4 to 7 years of age to ride in a booster seat. The law provides for a State tax credit of \$25 per year toward the purchase of a booster or child safety seat. Educational efforts about the new law included letters to retailers, display of public banners, television PSAs by DOT, a radio campaign by State Farm Insurance, and pay stub announcements for state employees.

A DOT grant continued to fund training for technicians through the Child Passenger Safety (CPS) Program. Two more hospitals became CPS inspection stations (Tripler Army Medical Center and Kaiser Permanente). KIPC and Kapiolani Medical Center (KMC) continued to maintain a safety seat inspection station at the hospital with a technician trained in fitting children with special needs.

Enforcement of the State's mandatory seat belt and child safety seat laws continued through the annual "Click It or Ticket" campaign. During the 2-week program, DOT conducted an aggressive media campaign about the state's passenger restraint laws in conjunction with high visibility enforcement efforts by all 4 county police departments. Special emphasis is placed on the \$92 fine paid by violators.

The 2007-2012 Hawaii Strategic Highway Safety Plan was released in August 2007. More than 150 people from law enforcement, health and community organizations, such as Mothers Against Drunk Driving-Hawaii Chapter and AARP-Hawaii worked in groups to select key strategies to address: aggressive driving, impaired driving, occupant protection, pedestrians and bicyclists, motorcycles and mopeds, facility design and data, and data management systems. The 5th highest pedestrian fatality rate from traffic crashes in the United States over the 2001-2005 period occurred in Hawaii. The highest non-fatal pedestrian crashes occurred in children 5-19 year age, with higher rates among the 10 to 14 year-olds.

Pedestrian and bike safety was included in the State Highway Safety Plan for the first time. The Safe Routes to School Program under the DOT, received its \$1 million annual allocation in federal transportation funds to help encourage more children to walk and bicycle to school by creating safer and more enjoyable roadway conditions around schools. DOT funded the "Safe Kids Hawaii-Walk To School Day" held in October at Kalihi Waena and Ala Wai Elementary Schools with support from FedEx.

In the 2006 General Election residents voted to make Honolulu a pedestrian and bicycle friendly City by amending the City Charter. DOH is supporting community advocates to help assure the City begins implementation of the new charter language. State legislation was passed to fund a comprehensive state pedestrian program, but was vetoed by the Governor due to a dispute over the source of funding.

The Child Death Review Report: 1997-2000 was released in November 2006. Findings included 73% of children who died in motor vehicles were not wearing seatbelts. The State/Local CDR teams use the report to identify system and policy changes to improve child safety.

The 2007 Hawaii Child Restraint Use Survey, funded by DOT, showed a decrease in restraint use among infants and toddlers. The toddler compliance rate saw a decrease from 74.0% in 2006 to 62.3% in 2007. The compliance rate for infants remained largely the same (from 91.7% to 91.5% in 2007).

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

The 2008 Legislature passed a law that 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. The bill also requires the drivers' exam to include information on this offense and requires notice of the law in rental cars. The Governor signed the bill in June.

The DOH Injury Prevention and Control Program developed a media campaign "No Get Hurt Hawaii. Injuries are Preventable" with support from a Centers for Disease Control grant. Pedestrian and bike safety PSAs are also available.

To increase enforcement of the booster seat law, KIPC will provide on site in-service for Honolulu Police during all three work shifts this year. The 2008 "Click It or Ticket" campaign was conducted in May.

Twenty five CPS certificate technicians were trained using a new 4-day curriculum which emphasized parent participation in all car seat installations. KIPC and Kapiolani Medical Center (KMC) continue to work on the issue of providing transportation for children with special needs.

The DOH Healthy Hawaii Initiative helped fund Walkable Community workshops in November 2007 and March 2008 to train neighborhood leaders to assess roadway conditions and identify recommendations to make their communities safer and more enjoyable for walking.

c. Plan for the Coming Year

Title V will continue to monitor data for child motor vehicle-related deaths and report rates. Provisional data will be updated in next year's report. Objectives are set for no more than 2 deaths per 100,000 annually.

Title V partners will continue to educate families about best practices related to promoting child passenger safety by supporting activities for car seat installation services. Services will be expanded to address the decreased use of safety restraints and improper installation of car seats. Integration of child safety seat training into existing programs for families with young children will be supported. KIPC plans to develop a campaign to address the three most common causes for incorrect installation of child passenger seats.

Title V will continue to support IPCP and DOT in their activities to promote compliance with existing child passenger safety laws. Plans include monitoring compliance with the new booster seat law through the 2008 Child Restraint Survey.

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.

The Child Death Review system continues to identify and increase awareness of risk factors occurring in child deaths related to motor vehicle crashes and pedestrian deaths through a multidisciplinary approach to recommend prevention strategies.

Child passenger safety information and educational resources will continue to be included in the broader spectrum of injury prevention and will be made available to contracted service providers and programs supported by Title V.

The DOT anticipates continuation of Federal transportation funds to conduct the highly successful "Click It or Ticket" car restraint enforcement campaign.

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	2003	2004	2005	2006	2007
Annual Performance Objective				46	47
Annual Indicator			55.5	50.7	50.7
Numerator			178	112	112
Denominator			321	221	221
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
	2008	2009	2010	2011	2012
Annual Performance Objective	48	49	50	51	52

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.

Notes - 2005

This data for this measure is from the National Immunization Survey (www.cdc.gov/breastfeeding/NIS_data/state.htm) by the Centers for Disease Control (CDC). The latest data is from 2004 and is reported for 2005. The data will be updated in next year's report.

a. Last Year's Accomplishments

The FY 2007 data (based on NIS data for infants born in 2004) indicates 50.7% of Hawai'i mothers reported breastfeeding their infants at 6 months, a decrease from 55.4% from the previous year's data (infants born in 2003). However, the differences may be due to statistical variability. Hawaii has seen an overall increase from 1999 (49.3%) when the NIS first started collecting breastfeeding data. The 2007 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%.

Based upon this year's data, Hawaii is only one of eight states (Alaska, California, Hawaii, Montana, Oregon, Utah, Vermont, and Washington) that achieved all three Healthy People 2010 objectives - 75% of mothers initiating breastfeeding, having 50% of mothers breastfeeding their infant at 6 months of age, and 25% of mothers breastfeeding their infant at 12 months of age.

The Title V program promotes breastfeeding by providing enabling, population based, and infrastructure building services. 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, and breastfeeding peer counselors (BFPC). WIC maintains state and local agency level breastfeeding coordinators (BFC).

WIC initiated a pilot program in July 2007 that gives exclusively nursing mothers meeting specific criteria a personal-use pump to extend the duration of exclusive and any breastfeeding. WIC arranged for the BFC or a designee to attend a five day certified lactation counselor training in March 2007. Trainees took an exam to receive certification. WIC's state level BFC position was filled in June 2007. WIC organized and participated in the August 7, 2007 multi-state Breastfeeding Awareness Walk initiated by California in honor of World Breastfeeding Week. This event drew breastfeeding mothers, medical staff from local hospitals, Department of Health staff, La Leche League leaders from Oahu and neighbor islands, and community partners including the Breastfeeding Promotion Council of Hawaii (BPCH).

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.

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 BPCH provides leadership for breastfeeding promotion in the state. The Council has a website with information on services for breastfeeding mothers. Annually, the Council honors individuals and programs that support breastfeeding.

WIC provides 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.

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. Also, at Windward WIC, two trainees completed the BFPC didactic training in April 2007 and began the practicum portion of the training.

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

WIC continues to focus on breastfeeding promotion, education and support to their pregnant and postpartum clients. WIC provides breastfeeding incentive items, electric breast pumps or free

manual pumps if needed. Details are available on the website at www.hawaiiwic.com. The nationally recognized PITS Program continues to be conducted in 18 high schools statewide. A six-hour training is being provided to all WIC staff in the state on communication skills, risks of formula use, the case for exclusive breastfeeding, and overcoming barriers.

The BPCH annual conference featured nationally renowned speaker, 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.

The BPCH is promoting lactation support in the workplace. They are 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 at a national conference in Arlington, Virginia.

PACT is training four BFPCs at Wahiawa WIC. All WIC staff at Waianae Coast Comprehensive Health Center are receiving training in the BFPC program and two staff members will be designated as BFPCs when the training is done.

After reviewing this year's data it was decided that objectives would not be reset.

c. Plan for the Coming Year

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.

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 BPCH and legislation to assure employees are provided adequate pumping breaks and continue to assure that breastfeeding women are protected from discrimination.

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 expand the BFPC Project to train additional BFPCs and in the future to expand their 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. WIC will be evaluating the personal use pump program for its success in promoting exclusive and any breastfeeding and its cost effectiveness.

WIC will continue efforts to secure a breastfeeding professional position across all Department of Health programs. WIC activities around World Breastfeeding Week will increase awareness and

support for the benefits of breastfeeding.

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	2003	2004	2005	2006	2007
Annual Performance Objective	98	98	98	98	98
Annual Indicator	97.8	98.0	97.6	98.3	98.1
Numerator	17678	17882	17417	18573	18725
Denominator	18082	18246	17839	18888	19085
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
	2008	2009	2010	2011	2012
Annual Performance Objective	98	98	98	98	98

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.

Notes - 2005

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 is provisional and will be updated in the next report.

a. Last Year's Accomplishments

The 2007 indicator was 98.1%. The objective was met. Data for CY 2007 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 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. Several hospitals have obsolete backup equipment which should be replaced.

In 2007, the number of hospitals delivering and screening babies decreased from thirteen to 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. Aggregate data has not been adequate for state follow-up purposes. Discussion continues with the hospital regarding child specific data submission.

NHSP continued to work with hospitals and physicians in 2007 regarding follow-up for infants who needed rescreening or audiological evaluation. Hospitals received data on their hearing screening performance to identify problems, improve services, and track progress. In addition, NHSP worked with hospitals monthly to reconcile state data against hospital delivery logs and track follow-up needs.

NHSP continued to support air transportation to Oahu for audiological evaluations, since the necessary equipment is not available on Neighbor Islands. Additional diagnostic equipment was ordered in 2007 for loan to four Neighbor Island audiology clinics to help expand access to pediatric audiological evaluations.

The hospital newborn hearing screening coordinators subcommittee met in June 2007 for an update on changes to the Joint Committee on Infant Hearing (JCIH) position statement, genetic factors related to hearing loss, screening procedures, and data requirements. The Early Hearing Detection & Intervention (EHDI) Advisory Committee met in November 2007 for an update on changes to the JCIH position statement and to give input on draft administrative rules, draft genetic brochures, draft manuals for families and healthcare providers, and proposed grant activities.

In 2007, early intervention (EI) care coordinators verified that they are obtaining consents from families to allow the exchange of information with NHSP. Initial steps were taken to add consent status fields on Part C related databases to facilitate electronic matching with the state's EHDI database.

Funding from the MCH Bureau for the Baby Hearing Evaluation and Access to Resources and Services - Hawaii (Baby HEARS-Hawaii) project supported the CSHNB/NHSP efforts to improve newborn hearing screening and follow-up in Hawaii during 2007.

Administrative rules for NHSP were submitted in 2007 for administrative review and revision.

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		X		X

impact on screening rates.				
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. When needed and funds are available, NHSP provides loaner screening equipment to hospitals. Screening equipment has been ordered for loan to three 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.

In-service training is provided for hospital staff, audiologists, physicians and EI providers to improve the quality of screening and follow-up. NHSP works with American Academy of Pediatrics Hawaii Chapter EHDI Champion to plan and provide technical assistance and training.

NHSP continues to develop/disseminate educational materials to inform parents and providers about newborn hearing screening and the importance of EI services for infants with hearing loss. NHSP brochures were sent to hospitals in 12 languages and are available on the NHSP website at <http://health.gov/health/family-child-health/eis/nhsp.html>. A practitioner's manual has been developed and is being disseminated to hospitals and other healthcare providers.

NHSP activities are supported by the Baby HEARS-Hawaii follow-up grant and by state funds.

c. Plan for the Coming Year

The target for this objective remains at 98%. Although the objective was met in 2007, data is preliminary. Once data is finalized, consideration will be given to changing activities if necessary.

Newborn screening will continue in all birthing facilities. NHSP will assist with follow-up for infants who need rescreening or referrals for audiological assessments, as well as for infants being monitored for late onset of hearing loss.

Data collection and tracking procedures will be improved. The program will establish linkages with other public health and early intervention databases to help locate children who are otherwise lost to EHDI follow-up or 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/loss to 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/loss to 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. Dissemination of the EHDI practitioner's manual will be completed. Hospital screener training materials will be disseminated.

The Baby HEARS-Hawaii grant project ended in March 2008. NHSP has been awarded a 3 year continuation grant which began in April 2008. Through the Baby HEARS follow-up project, a full-time Project Coordinator will be hired to conduct grant-related pilot projects across the state and to assist with overall grant management. A part-time Parent Coordinator will be hired 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. A part-time Audiologist will be hired 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 its subcommittees will continue to meet and provide input on state program policies and procedures.

The process to establish administrative rules will continue and is expected to be completed in 2008.

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	2003	2004	2005	2006	2007
Annual Performance Objective	3.2	2.7	2.3	1.8	1.8
Annual Indicator	2.9	3.7	2.1	2.2	2.2
Numerator	8387	10802	6343	6343	6343
Denominator	291109	295174	295999	292999	292999
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
	2008	2009	2010	2011	2012
Annual Performance Objective	1.4	0.9	0.5	0	0

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 on this measure by the year 2010. The 2006 survey data is not yet available.

Notes - 2005

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 on this measure by the year 2010.

a. Last Year's Accomplishments

Data for 2006 and 2007 numerator was not available for this measure due to weighting issues. The data will be updated next year. This measure is related to Healthy People 2010 Objective to increase the proportion of persons with health insurance to 100 percent. A recent national report on children's health care released by the Commonwealth Fund ranked Hawaii 4th in the U.S. for insurance coverage, using 2005-06 data.

The thrust of the Title V agency's efforts to decrease the percentage of children without health insurance are 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 phone, the trend toward more cell phone use along with the cancellation of residential phone lines. There are also small fluctuations in the data, probably due to sampling variability, small sample size and weighting of the sample. Because of the limitations of the HHS, the Title V agency collaborated with Hawaii Covering Kids (HCK) to review various data sources to obtain a better estimate of uninsured children.

Two programs designed to improve children's access to health insurance continues. SCHIP, a Medicaid expansion program, covers children up to 19 years of age with family incomes up to 300% of the federal poverty level (FPL) for Hawaii. In 2006, the Medicaid eligibility for children was increased from 200% FPL to 300%. Families who make up to 250% FPL receive free health insurance for their children and families between 251-300% FPL pay reduced monthly premiums.

The state-funded Immigrant Children's program targets lawful permanent residents (have a "green card"), refugees, and those born in the Marshall Islands, Federated States of Micronesia and Palau. It has the same eligibility requirements as SCHIP. As of December 30, 2007, there were 18,043 enrolled in SCHIP and 3,203 enrollees in the Immigrant Children's program.

Hawaii Uninsured Project's (HUP) efforts continued through a committee of advocates, health care and health coverage experts, and state officials to develop and analyze potential solutions for increasing coverage for children until December 2006. Since no further funding was obtained, the formal program ended.

Hawai'i Covering Kids (HCK) continued to receive funding from Aloha Care, HMSA Foundation, Med-QUEST (Hawaii Medicaid program), and the NFL Pro Bowl Charities. HCK convened its Process Simplification Task Force to address the Medicaid documentation mandate in the federal Deficit Reduction Act that went into effect on July 1, 2006. This measure required all Medicaid recipients to prove U.S. citizenship or alien status and provide photo identification to receive benefits. The goal of the task force was to assure that health insurance not be terminated for eligible recipients and to enroll eligible applicants through an efficient process.

HCK continued to inform parents and guardians about free health insurance through linkages with public and private schools, WIC, Head Start, County Department of Parks and Recreation, youth

clubs, public housing agencies, 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.

The 2007 Legislature passed the Keiki Care bill which established a 3-year pilot program to address health insurance gaps for children. Provisions include covering premium payments for children in Med-QUEST's programs whose household incomes are between 251-300% FPL, free health insurance in a limited benefit package called Keiki Care for children ages 31 days to 19 years who are ineligible for QUEST or Medicaid and who have been continuously uninsured for six months, and an Infant Care Fund to provide a maximum of \$10,000 per uninsured newborn up to 31 days of age who is not covered under any other health insurance plan.

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 of new strategies and models for outreach and enrollment.				X
3. Require Title V contractors to refer eligible uninsured children for insurance coverage.				X
4. Implement provisions of new Medicaid waiver expanding coverage for children up to 300% FPL.				X
5. Implement & monitor results of 3-year pilot Keiki Care program to provide insurance coverage & assistance with premium payments for the gap group of infants and children up to 300% FPL.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

HCK outreach program includes flyers published in 20 languages and 3 immigrant media campaigns were conducted in 10 languages using various media.

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 cost for the program will be monitored to determine sustainability.

HCK partnered with Community Clinic of Maui at the annual Maui Children's Health Day to provide information to parents/guardians about the new Keiki Care plan. HCK conducted outreach to displaced employees affected by company closures about health insurance for their children, including radio public service announcements, community newspaper advertisements, and participating in outreach events. A Children's Health Insurance Policy Forum in Hawaii was sponsored by HCK on April 16, 2008 to present information about recent federal policies and their implications for our children's health insurance programs.

The Legislature passed a bill to extend health care benefits to the nearly 900 children of displaced workers affected by the shutdown of two airline companies that service Hawaii. The coverage would be provided under the state's Keiki Care plan.

Title V service contracts continue to require appropriate referrals for uninsured children who are eligible for health insurance coverage. Out-stationed Med-QUEST eligibility workers are available at community health centers and hospitals across the state.

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.

Infrastructure building services will continue. In partnership with the Hawaii Covering Kids (HCK), the Title V agency will reach consensus on the most valid and reliable method of obtaining numerator and denominator data for the percentage of uninsured children. This may involve two or more data sources for the numerator and may change the future objectives for this performance measure that use only the annual Hawai'i Health Survey data. The objectives are currently projected with the FY 2000 indicator as the base, to result in zero in 2010.

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.

The enrollment figures and cost for the state's 3-year pilot Keiki Care plan will be monitored to determine sustainability of the program. A report covering the first year of operations will be due to the 2009 Legislature. Policy will be drafted to ensure that all children in the state have access for affordable 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	2003	2004	2005	2006	2007
Annual Performance Objective				22	22
Annual Indicator		23.5	22.4	22.4	22.4
Numerator		3670	3500	3500	3500
Denominator		15616	15624	15624	15624
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
	2008	2009	2010	2011	2012
Annual Performance Objective	21	20	19	18	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.

Notes - 2005

This is a new National Performance Measure added in for the five-year report period, FY 2006-2010.

Data is for FY2004. The 2005 data is not yet available.

a. Last Year's Accomplishments

The latest available data is for 2005. There were some data quality issues with the 2006 WIC dataset which have since been addressed. The 2006 WIC data is being resubmitted to CDC for consideration and analysis. The 2007 WIC data is currently under review by CDC. No problems are anticipated.

The data for 2005 indicates 22.4% of WIC children age 2-5 years were or at-risk for overweight or obesity. The state objective was nearly met. Hawaii rates compared well to the overall U.S. (31.2%) for the same year.

WIC conducted trainings on the Participant Centered Education (PCE) approach to improve staff effectiveness during counseling. PCE is an educational approach that focuses on participant concerns and involves them in making decisions and solving problems. The PCE model improves delivery of nutrition education and increases effectiveness in promoting behavioral changes.

WIC supported and promoted CDC's "Produce for Better Health Foundation Fruits & Veggies -- More Matters" (FVMM) national campaign. WIC adapted a curriculum to coincide with the FVMM national launch in March 2007. Five thousand "Eat 'Um" books developed by the local community action program were given to WIC families to promote fruit and vegetable consumption.

WIC nutritionists also educated childcare providers on how to incorporate more fruits and veggies in children's diets based on their readiness to change at the Hawaii Association for the Education of Young Children's Health Symposium in April 2007. Sessions also included increasing children's physical activity during the school day and promoting healthy eating and physical activity for providers and other staff.

WIC held their biennial conference "Growing Healthy Families: Cultivating Wellness at WIC" for staff. Among the objectives of the conference were to identify strategies to help improve working relationships, service to the client/customer, and conflict resolution skills with clients, co-workers, and supervisors and learn practical interventions to help defuse difficult people, including strategies to defuse, deflect, and disarm verbal conflict.

Title V continued to contract with community health centers statewide to provide primary care to the uninsured population. An annual variance report provides information on the BMI status for all children to assure that an assessment and education is included if the child is overweight.

Title V continued as a member of the Health Advisory Committees of the two Head Start Programs on Oahu, assisting with training and policy development. One of the projects is the development of a Wellness Plan. The Plan addresses goals and objectives for children, families and staff for the coming year to increase healthy eating and physical activity.

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). Trainings are being conducted on the toolkit for pediatric providers statewide including WIC.

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 August 2007.

HHI formed a statewide Physical Activity and Nutrition (PAN) Coalition that developed working objectives now being reviewed for implementation 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. Support community based organizations (like Head Start) to plan and conduct health promotion activities and projects.				X
5. Implement action plans related to diet and physical activity.	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. Provide training for WIC/pediatric providers to improve weight related behaviors of families with young children.				X

b. Current Activities

WIC is providing mentoring for staff on the PCE approach to ensure effectiveness during counseling. Also, advanced training for staff on PCE has continued this fiscal year. WIC is also providing training to designated staff at local agencies on learning mentoring techniques to ensure on-going quality assurance and guidance for staff utilizing PCE.

WIC continues to provide education and information on appropriate dietary practices. Efforts will be directed to decrease rates that have largely remained stable over the past 4 years. WIC plans

on implementing low fat milk food packages for children ages 2-5 and for pregnant and postpartum women. WIC will continue 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). The upcoming revision of food packages will allow the purchase of fruits and vegetables.

Title V continues to monitor BMI data submitted on an annual variance report by community health centers who have contracts to serve the uninsured. In February, 2008, Title V sponsored a training for pediatric providers, EPSDT coordinators and Title V staff on the "Hawaii Pediatric Weight Management Toolkit."

c. Plan for the Coming Year

Quality issues with the 2006 WIC dataset have been addressed and data will be updated. No problems are anticipated with the 2007 dataset and results should be included in next year's report. Objectives for this measure have been set to decrease one percentage point annually.

WIC will implement use of a revised assessment tool which can more thoroughly assess a family's overall eating habits. The assessment tool focuses on the quality of the individual's diet versus quantifying servings based on a 24 hour recall. Revisions incorporated include: assessing for non-nutrient dense beverages; differentiating between whole grains and refined grains; and assessing for consumption frequency of 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 will include consistent recommendations and goals utilized in the Hawaii Pediatric Weight Management Toolkit sponsored by HMSA, Pediatric Foundation of Hawaii, and Hawaii Chapter of the American Academy of Pediatrics.

WIC materials will also be developed to educate parents and caregivers on encouraging physical activity and provide suggestions that are developmentally appropriate for children 1 through 5.

Title V will continue to participate in the Physical Activity and Nutrition Coalition Workgroup to address the objective to improve physical activity and nutrition in preschool and childcare facilities. Specific activities include developing curriculum and educational information, promoting guidelines and policies, supporting breastfeeding and educating parents and childcare providers.

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	2003	2004	2005	2006	2007
Annual Performance Objective				8	8
Annual Indicator		8.1	8.4	9.4	9.4
Numerator		1420	1440	1716	1716
Denominator		17633	17233	18300	18300
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
	2008	2009	2010	2011	2012
Annual Performance Objective	7	7	6	6	5

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.

Notes - 2005

This is a new National Performance Measure added in for the five-year report period, FY 2006-2010.

Data for this measure comes from the Hawai'i Pregnancy Risk Assessment Monitoring System (PRAMS) and vital statistics. 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 2003 is the latest available.

a. Last Year's Accomplishments

Smoking is the single largest known preventable risk factor for poor pregnancy outcomes and is responsible for 5% of all perinatal deaths. The 2006 data (latest available data) indicates 9.4% of pregnant women reported smoking during pregnancy. The state objective was not met.

The percentage of women who report smoking during pregnancy has remained stable over the past 5 years. Hawaii's prevalence rate compares well to other PRAMS states that range from 6.8% to 25.3% (2002 data).

In July 2007, Title V Perinatal Support Services (PSS) contracts were modified to include specific language to address smoking in the perinatal period. PSS providers continue to use Brief Intervention counseling techniques to increase tobacco cessation during pregnancy. PSS client data forms were also revised to include reporting on smoking behaviors.

The PSS advocacy and training contract was awarded to Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii that also began in July 2007. HMHB provided ongoing smoking brief intervention training and maintained a phone line and website that includes smoking cessation resources. HMHB also participated in the Prenatal Smoking Workgroup convened by Title V to decrease tobacco use in the population.

The Hawaii County Perinatal Health Disparities Program services was contracted out to a community agency to serve Hawaiian, Other Pacific Islander, Hispanic and adolescents during pregnancy and two years during the interconception period. Clients are screened for risk behaviors and provided intervention services for those women who smoke. Specific language to address smoking, in the perinatal and interconception periods, was included in service contracts that began in October 2007. The same form developed for PSS is being utilized to capture smoking data. The program is funded by a federal Healthy Start grant.

The Baby Substance Abuse Free Environment (Baby S.A.F.E.) program for substance-using pregnant women provided education and smoking brief intervention counseling for individual clients. The importance of smoking cessation during pregnancy is also covered in group health education classes. Information is provided as part of outreach activities like community health

fairs. Baby S.A.F.E. providers have used smoking brief intervention screens on pregnant women to initiate discussion and screen for other substance abuse problems when conducting outreach for Baby S.A.F.E. pretreatment services.

The WIC program screens clients for smoking during pregnancy and makes referrals for further assistance at the initial client visits using a health questionnaire.

Title V participated in the March of Dimes Hawaii Chapter 3rd Annual Prematurity Awareness Summit. Information was presented on the Neonatal Intensive Care support program and the importance of preconception care in addressing preterm birth. Research showing smoking during pregnancy has been a contributing factor for preterm and low-birth weight was also discussed.

The Pregnancy Risk Assessment Monitoring System (PRAMS) collected population based data on smoking behavior during pregnancy and provides the data for this measure. Although the PRAMS Coordinator position is vacant again, the Hawaii survey managed to maintain a 70% response rate, the minimum required by the CDC for a valid dataset.

Title V worked closely with providers and stakeholders to address smoking cessation interventions during and after pregnancy. A Prenatal Smoking Workgroup was formed to address this issue. The work group met quarterly, identifying legislative strategies, reviewing data, improving collaboration between programs, and identifying potential projects.

Tobacco prevention and control programs continued aggressive media and counter-marketing initiatives targeting youth and increased public awareness on adverse effects of secondhand smoke, predatory tobacco industry tactics, and the addictive nature of tobacco. Media ads also targeted parents to consider the adverse effects of their smoking behaviors on their young children.

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				X

cessation for women before, during and after pregnancy.				
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

Title V programs continue to screen all high-risk pregnant women for substance use including cigarette smoking. The HMHB facilitated training for program providers on Basic Tobacco Intervention Skills certification and Basic Intervention Skills Instructor Certification training. Nine providers received certification for Basic Tobacco Cessation and two providers became certified instructors.

The Prenatal Smoking Workgroup continues to meet regularly and share promising practices for intervention to assist pregnant women to stop using tobacco. Due to the advocacy efforts of the workgroup, a resolution was introduced in the 2008 Hawaii legislature requesting the Department of Human Services to collect data and report how counseling coverage could be provided to all Medicaid beneficiaries, including pregnant women, wishing to quit smoking. The workgroup also provided expertise in assisting the PRAMS Steering Committee to select appropriate survey questions in the upcoming 2009 PRAMS survey.

HMHB used radio media messages in 11 dialects focused on pregnant women to stop smoking and also provided education to obstetrician-gynecologists regarding brief intervention and cessation resources.

The Hawaii Tobacco Quitline continues to provide free statewide telephone counseling services to all tobacco users, including pregnant women. In addition to counseling, the Quitline provides information regarding community resources available to the tobacco user to assist in tobacco cessation.

c. Plan for the Coming Year

Data for PRAMS will be updated in next year. The objectives for this measure have been set to decrease 1 percentage point every 2 years to assure progress in achieving the Healthy People 2010 objective of 1%. Title V will also address increasing smoking cessation in the preconception period and work to assure women do not resume smoking during the post-partum period.

Title V (PSS and Baby S.A.F.E) and the Hawaii County Perinatal Disparities program providers will continue service and data collection on the use of tobacco and provide program and referral interventions. Program providers will continue to conduct tobacco cessation services to high-risk pregnant women.

Title V will develop a web-based perinatal data collection system for program providers and replace the hard-copy data collection forms. Using computer technology will increase efficiency for data entry, collection and invoicing for services. Data access for analysis, program evaluation and reports will be available to perinatal program providers including prevalence rates of smoking during pregnancy and the interconception period.

The Baby S.A.F.E. purchase of service contract will be revised for the 2009 fiscal year. Costs for conducting Baby S.A.F.E. services will be determined so that motivational interviewing activities such as smoking brief intervention can be reimbursed at a unit cost rate. The contracted services will continue to provide outreach, assessment/screening for early identification of substance use, education and intervention for tobacco cessation through its individual and group support services. Title V will oversee the follow-up support for the Motivational Enhancement Services

Training (Motivational Interviewing) to program providers. The follow-up will address provider needs/issues to support improved service delivery.

The HMHB will continue to provide training of perinatal program providers on smoking brief intervention to reduce the rate of smoking during pregnancy and advocate for legislative bills aimed toward this focus. HMHB will also coordinate and assist Title V in planning for the Perinatal Summit in October 2008 that will address various perinatal topics including issues related to smoking during pregnancy.

The Prenatal Smoking Work Group plans to explore the feasibility of expanding the Hawaii Tobacco Quitline specifically to help pregnant women increase their chances to quit smoking and remain tobacco-free after the baby is born. Another promising practice that the group would like to explore is the use of a carbon monoxide breathalyzer to monitor smoking cessation efforts of pregnant women attending WIC Clinics. Pregnant smokers that show decreased carbon monoxide levels would receive free diapers as an incentive to quit smoking during pregnancy and to remain smoke-free after delivery.

WIC will also continue using their health questionnaire as an initial client assessment 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	2003	2004	2005	2006	2007
Annual Performance Objective	6	5	9	9	8
Annual Indicator	7.9	8.2	8.2	8.2	8.2
Numerator	20	20	20	20	20
Denominator	254619	245172	243426	245087	245087
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
	2008	2009	2010	2011	2012
Annual Performance Objective	8	7	7	7	7

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.

Notes - 2005

Data is for resident population and is by calendar year. Data for the year 2004 was revised with an updated death data file. Data for the year 2005 is based on a provisional death data file. 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 for this measure because the numbers are small and vary substantially from year to year. The provisional data for the 2006-07 indicator is 8.2. The state objective was nearly met. The rates have stayed relatively stable over the past 5 years for this measure.

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 High School and Middle School students. The survey includes questions on suicidal thoughts and behavior as well as protective factors. In comparing Hawaii YRBS results with other high school students in the U.S, Hawaii's youth had one of the highest rates in the nation for suicide ideation.

The Child Death Review (CDR) National Resource Center's web based pilot "Child Death Review Case Report", has continued to collect an expanded description of suicide circumstances to begin standardization of multi-state reporting of suicide findings and actions.

In February 2007, the DOH and the 29 members of the Suicide Prevention Task Force (SPTF) began participation with Mental Health America of Hawaii's Faith-based Suicide Prevention Planning Committee in its effort to reach out and educate clergy about the issue of suicide and suicide prevention. The SPTF members come from government, public health, education, human services, business and other areas with experience or knowledge of suicide and suicide prevention across the lifespan. Title V continued to participate as a Task Force member keeping adolescent risks and issues in the forefront.

The Hawaii Suicide Prevention Education Awareness Research (SPEAR) Foundation provides information on suicide awareness and prevention to high school students statewide. 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.

In May 2007, DOH's Suicide Prevention Coordinator position became permanent and funding for "Youth Suicide Prevention" in the Omnibus Budget Bill was appropriated by the Hawaii State Legislature. A provision of \$100,000 for FY08 and FY09 was made to DOH to develop suicide prevention programs.

In June 2007. The governor signed HB55 into law as Act 124-relating to youth suicide prevention, establishing educational and early intervention prevention programs to address the rising rates of suicide ideation and suicide rates of Hawaii's youth.

A total of nine community Applied Suicide Intervention Skills Training (ASIST) sessions, reached 198 participants who are trained in suicide "first aid." Adult Mental Health Division (AMHD) has committed to training 200 of their mental health staff during the coming year.

DOH's CAMHD and the University of Hawaii have collaborated to form an Evidence-Based Prevention Programs (EBPP) Committee to review research literature on the most effective prevention programs that target children's emotional health and well being as an outcome.

Title V participated in the planning and coordination of Hawaii's first Suicide Prevention Conference, "Building a Safety Net-Getting Connected for Suicide Prevention.

By year end, DOH sponsored 15 community ASIST workshops with 343 trained gatekeepers.

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 statewide suicide prevention plan.				X
3. Develop greater coordination and collaboration to address suicide prevention.				X
4. Identify 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 in the plan.				X
10.				

b. Current Activities

The youth suicide prevention program is managed by the Department of Health, Injury and Prevention Control Program with an approved budget of \$100,000 to establish educational, early intervention and prevention programs to address the rising rates of youth suicide, for each of 2 fiscal years, starting July 1, 2007.

The first Suicide Prevention Conference was held October 2007 with national speakers and public figure survivors as presenters. More that 250 people attended the two day conference which included representatives from public and private agencies and community members. Plans for the November 2008 Statewide Suicide Prevention Conference are underway.

The SPTF has reorganized and conducts meetings every other month. A core group has been formed to address matters that require a more timely response such as legislation.

There are now 34 national ASIST trainers in Hawaii, up from nineteen in 2007. Each trainer attends intensive 5 day training classes and commits to conducting a minimum of 3 community training sessions and also assumes responsibility as the ASIST trainer for their agency staff.

In March 2008, the Suicide Prevention Action Network (SPAN) USA recognized Pua Kaninau, the past chair of the SPTF, for her grass-roots contributions to suicide prevention. The Suicide Task Force will continue to work on the goals and objectives of the Hawaii Injury Prevention Plan.

c. Plan for the Coming Year

Title V will continue to monitor data for teen suicide and report rates. Provisional data will be updated in next year's report. Objectives are set for a 1% point reduction every two years based on the FY 2000 indicator.

The reduction of adolescent suicide is a priority of the SPTF as well as for all of Hawaii's citizens. Strategies include increasing awareness about the problem; recognizing the link to mental health and substance abuse disorders; improving health care access; and maintaining a surveillance system for all ages across the lifespan.

Statewide, ASIST trainings will continue to be conducted and the goal is to increase the number of ASIST trainers in the four counties. This will build capacity in each county as well as increase the individual's awareness and knowledge about suicide signs and symptoms, effective methods to provide assistance, and assure appropriate referrals for intervention services.

Mental Health America Hawaii participates as an active member of the SPTF and has received a grant from the National Institute of Mental Health to expand their speaker's bureau into a faith based community outreach program in cooperation with Pacific Health Ministry and community religious leaders to address mental health issues including depression and suicide prevention.

The Child & Adolescent Mental Health Division (CAMHD), Adult Mental Health Division (AMHD), the Emergency Medical Services (EMS) and the Injury Prevention and Control Program (IPCP) will continue to develop and implement adolescent suicide prevention strategies and activities.

The Hawaii SPEAR Foundation will continue to increase awareness and education of suicide as a public health problem, remove the stigma, identify those at-risk and provide support to survivors. This community based organization will actively support and sponsor the conference planning and implementation.

Title V will continue to be involved in planning the second annual Statewide Suicide Prevention Conference scheduled for November 21, 2008. The National Center for Child Death Review will provide a speaker for the conference and the Hawaii Child Death Review Council will sponsor a training the day before to maximize the available national resource speaker.

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	2003	2004	2005	2006	2007
Annual Performance Objective	86.4	86.9	87.5	88	88.5
Annual Indicator	85.7	88.7	89.3	88.5	88.7
Numerator	215	211	216	223	205
Denominator	251	238	242	252	231
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
	2008	2009	2010	2011	2012
Annual Performance Objective	89	89.5	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 Hawai'i: 1) Kapi'olani Medical Center for Women and Children, 2) Tripler Army Medical Center and 3) Kaiser Permanente Moanalua Medical Center.

The determination of annual performance objectives beyond the year 2010 is on hold pending a comprehensive reassessment and critique of the indicator's past performance, issues and resources affecting the measure, and the release on the new Healthy People 2020 objectives.

Notes - 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.

Notes - 2005

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.

There are three medical facilities considered to be tertiary care centers in Hawaii: 1) Kapiolani Medical Center for Women and Children; 2) Tripler Army Medical Center; and, 3) Kaiser Permanente Moanalua Medical Center.

The performance measure objectives have been set to achieve the Healthy People 2010 objective in the year 2010.

a. Last Year's Accomplishments

Provisional data for 2007 indicate 88.7% of very low birth weight infants were delivered at facilities for high-risk deliveries and neonates. The objective was met. Hawaii is also very close to achieving 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 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.

AirMed is the air ambulance used exclusively by Kapiolani's neonatal and pediatric transport team. AirMed is the only accredited air ambulance service between the Hawaiian Islands on a 24/7 basis.

The Title V purchase of service (POS) contracts executed July 2007, for the Perinatal Support Services (PSS) for high-risk pregnant women and the Baby Substance Abuse Free Environment (Baby S.A.F.E.). Programs included objectives to decrease the incidence of low-birth weight infants. Both programs screen clients for alcohol and drug use, domestic violence and depression. These known risk factors contribute to preterm birth and low-birth weight neonates. Both programs offer care coordination and case management services to high-risk pregnant women to decrease the incidence of low birth-weight infants and poor birth outcomes.

Title V also allocated funding to the Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii to manage the statewide perinatal resource and referral phone line and MothersCare website. HMHB compiled comprehensive perinatal resources for the phone line and website to ensure women of childbearing age are provided timely and accurate perinatal information. HMHB also provided leadership for a legislative resolution requesting the DHS to collect data and report how counseling coverage could be provided to all Medicaid beneficiaries wishing to quit smoking, as smoking contributes to low birth weight babies.

The Perinatal Addiction Treatment of Hawaii (PATH) clinic began providing comprehensive prenatal and postnatal care to women who have a history of methamphetamine and other substance abuse in May 2007. Legislation in 2007 appropriated \$200,000 in general revenues for fiscal year 2007-2008 to be expended by the Department of Human Services for continuation of this pilot perinatal clinic on the island of Oahu.

The Hawaii County Perinatal Health Disparities Project received continued federal MCH Bureau funding and transitioned state services to 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 the Hawaii Island.

The Pregnancy Risk Assessment Monitoring System (PRAMS) data was analyzed for understanding behaviors in pregnancy that contribute to the incidence of VLBW infants being delivered.

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
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. Provide Hawaii County Malama Disparities Grant contract services for target groups through outreach and support services during pregnancy including addressing issues of low birth weight and access to 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. 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.				
10.				

b. Current Activities

Title V staff continues to oversee PSS and Baby S.A.F.E. contracts and program data will be analyzed in July 2008 to evaluate quality of service delivery and areas for improvement.

Federal Qualified Community Health Centers continue to deliver services and prenatal care to the Medicaid and non-insured pregnant women.

The PATH Clinic has served approximately 80 pregnant women since the onset of services.

The Perinatal Disparities Program continues to address priority objectives: increase entry into first trimester care, reduce the incidence of VLBW infants and infant mortality rates on the Hawaii Island. The key challenges to assuring access to medical care for pregnant women is the limited public transportation options, the long travel distances to health services, and rural isolation of many communities.

HMHB continues to provide statewide perinatal resources and referrals. In May 2008, HMHB facilitated a meeting between DHS Medicaid administrators and perinatal provider to discuss the barriers for expediting the MedQuest application process for uninsured pregnant women. HMHB also continues to conduct perinatal needs assessment for improving Title V program services.

AirMed now uses a rapid response team that reduces the air transport process to 15 minutes instead of the average of 1 hour.

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. Although the state objective was met, objectives will not be reset since the 2007 data is provisional. Once data is finalized, objectives will be reconsidered.

Title V will host a Perinatal Summit on Hawaii Island in October 2008 with funds received from a March of Dimes grant and other sponsors. The summit will feature Dr. Hani Atrash, Dr. Michael Lu and Dr. Juan Acuna as keynote speakers and nationally known researchers and leaders for improving perinatal health. Drs. Atrash and Acuna work at the Centers for Disease Control and Dr. Lu is an associate professor of obstetrics & gynecology and public health at UCLA. More than 200 perinatal stakeholders are expected to attend.

A request for proposal (RFP) will be developed by Title V staff for the Baby S.A.F.E. Program. The new service contract will require that data be reported utilizing a web-based data system currently in development. Contract language will continue to include outreach to screen and identify substance-using pregnant women in the first trimester of pregnancy. The PSS Programs will be evaluated by analyzing data and monitoring site visits. PSS contracts will be modified and extended, as appropriate to address poor birth outcomes, for another two year period (2010-2012).

The Perinatal Disparities Program will continue to address priority objectives: increase entry into first trimester care, the reduction of low birth weight infants and infant mortality rates. The 4 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. The HMHB service contract is also due to be modified and extended as appropriate for the 2010-2012 fiscal years.

The Hawaii 2008 Legislature did not provide additional funding to the PATH Clinic to continue beyond the 2 year project. The PATH staff is planning to seek grants and foundation funding to sustain clinic operations and provide multidisciplinary health care to substance-using pregnant women.

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	2003	2004	2005	2006	2007
Annual Performance Objective	85.4	86	81	82	83
Annual Indicator	80.4	79.0	79.1	79.0	77.9
Numerator	14522	14417	14151	14957	14863
Denominator	18066	18242	17882	18927	19077
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
	2008	2009	2010	2011	2012
Annual Performance Objective	84	85	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.

Notes - 2005

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.

The performance measure objectives have been revised based on the FY 2003 indicator with a 1% increase annually.

a. Last Year's Accomplishments

Provisional data for 2007 indicates 77.9% of pregnant women received first trimester prenatal care. The objective of 82% was not met for this performance measure.

Title V staff executed new Perinatal Support Services (PSS) contracts for high-risk pregnant women at 10 sites in the counties of Honolulu, Kauai and Maui in July 2007. As an incentive for improved performance, the PSS contract now reimburses providers at a higher rate for pregnant women seen in the first trimester of pregnancy. The post-partum period was also extended from 3 months to 6 months, to incorporate interconception health education including planning for a subsequent pregnancy.

The perinatal service contract awarded to Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii in July 2007 targets improvements to the perinatal system of care, including conducting needs assessment, advocacy, maintaining a comprehensive list of pregnancy resources, staffing for a referral and information phone line and website, and providing perinatal provider training. HMHB offers comprehensive perinatal resource information and referrals for the public trying to locate OB providers and prenatal care services. HMHB also provides assistance for accessing Medicaid insurance for uninsured pregnant women and monitors the time it takes to process Medicaid applications for these women.

Title V perinatal staff also oversees the Baby S.A.F.E. contract that provides pretreatment services to substance-using pregnant women. The program services are located on Oahu, Maui and the Hawaii island were contracted to 3 different non-profit agencies. The Baby S.A.F.E. contract has an outreach component to screen and identify pregnant women in the first trimester of pregnancy for services.

The federal Healthy Start Perinatal Disparities Grant program offered supportive services to high risk pregnant women in Hawaii County. A primary grant objective is outreach to populations that generally do not access prenatal care services specifically Native Hawaiians, other Pacific Islanders, Hispanics and adolescents.

Entry into early prenatal care is one of the performance measures used to evaluate the PSS, Baby S.A.F.E. and the federal Healthy Start Program contracts. Providers are also reimbursed at a higher rate for those women seen in the first trimester pregnancy.

Due to the closure of Wahiawa General Hospital's obstetrics unit in May 2007, women living in the rural/suburban areas of North and Central Oahu now need to travel 25 to 50 miles to the nearest birthing center. The hospital handled 240-300 births a year. The closure is indicative of

the high liability/operating costs to provide OB and prenatal care services to rural and neighbor island communities. The loss of perinatal providers and services will likely impact the state's prenatal care rate.

The Perinatal Addiction Treatment of Hawaii (PATH) pilot clinic for substance-using pregnant women began services in May 2007. The clinic provided comprehensive perinatal clinical and social services to women with a history of substance abuse, in a home-like setting free of judgment, and supportive of each women's unique path from pregnancy to capable parents. The clinic strives to provide services to a population that often avoids prenatal care due to discomfort with the perceived judgments of healthcare delivery providers, criminal justice concerns, and fears that their children may be removed from their care. Avoidance of prenatal care prevents women from taking in support and information during a time they may be most receptive to healthy behavior change.

The March of Dimes Hawaii Chapter provided funding to the Kalihi-Palama Health Center on Oahu for a Centering Pregnancy instructional workshop for health care professionals 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 and, improve the rates of pregnant women seeking early prenatal care through advocacy and educational activities. The first Centering Pregnancy group session was held in September 2007.

PRAMS continued to analyze and disseminate perinatal population data to support Title V efforts to improve the system of care for pregnant women and infants.

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. Provide Hawaii County Perinatal Disparities Grant contract services for target groups through outreach and support services during pregnancy including a focus on entry into first trimester pregnancy and ongoing prenatal care.	X	X		
4. Provide culturally competent service delivery through a variety of sources in areas with populations of higher risk women to improve outcomes related to infant mortality and morbidity.		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				X

issues.				
8. Support training opportunities for perinatal health providers.				X
9.				
10.				

b. Current Activities

The PSS Program continues outreach to the high-risk population for prenatal care access and provides health education that extends into the interconception period.

The Perinatal Advocacy Network facilitated by HMHB featured a speaker during a June 2008 video-conference that offered insight and useful approaches for encouraging immigrant women from the Republic of Marshall Islands (RMI) and the Federated States of Micronesia (FSM) to seek early and continuous prenatal care.

HMHB facilitated discussion between Medicaid administrators and perinatal providers in May 2008 to reduce the Medicaid application processing time for pregnant women. PRAMS data indicates the rate of pregnant women entering care in the first trimester is significantly lower among women whose deliveries were paid for by Medicaid versus non-Medicaid insurance (see HSCI 5c)

The Baby S.A.F.E. Program continues to offer clients free transportation to prenatal care visits to encourage early and continuous prenatal care for substance-using pregnant women.

The KP Health Center continues with the Centering Pregnancy group prenatal care sessions and has received additional funding from the March of Dimes to continue into the second year.

The federal Healthy Start program 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 access action plans.

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.

Title V staff from the Women's Health Section and federal Healthy Start program will host Perinatal Summit on the Big Island in October 2008. The Perinatal Summit is being funded by a March of Dimes grant and other sponsors. More than 200 perinatal stakeholders are expected to attend and listen to presentations by national perinatal researchers and leaders such as Dr. Hani Atrash, Dr. Michael Lu and Dr. Juan Acuna. Topics on cultural beliefs of child bearing as well as access to care will be addressed.

The service contract for PSS to high-risk pregnant women will continue into the second year. PSS contracts for current providers will be extended for an additional two years if service agreements are met. Performance measures include increasing the percentage of pregnant women receiving first trimester prenatal care.

A new request for proposal (RFP) for the Baby S.A.F.E. program will be announced in October 2008. The scope of services will be modified to include quality assurance measures such engaging substance-using pregnant women in the first trimester pregnancy.

With gas prices increasing, providing enabling services such as transportation to prenatal care is critical since more women may not be able to afford the cost of long distance trips to access medical services.

Findings for Title V Health System Capacity Indicator 5, comparing perinatal outcomes for Medicaid vs. non-Medicaid clients (including prenatal care), will be shared with the Medicaid agency as well as perinatal providers to help monitor quality assurance.

The Hawaii Island Perinatal Health Disparities Project will continue to target the Hawaiian, Pacific Islander, Hispanic and adolescent populations and use neighborhood women to outreach to those groups.

The Hawaii PRAMS datasets will be updated for 2007 and entry into prenatal care rates calculated.

The address the growing shortage of Ob/Gyns in private practice on the neighbor islands, legislation in 2007 to cap medical liability was introduced, but failed. As a compromise, Act 242 was passed which 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.

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	2003	2004	2005	2006	2007
Annual Performance Objective				48	47
Annual Indicator	49.6	49.6	52.4	52.3	52.3
Numerator	10894	10820	11329	12046	12046
Denominator	21975	21816	21636	23016	23016
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	46	45	44	43	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.

Notes - 2005

Data for this measure comes from the Hawai'i Pregnancy Risk Assessment Monitoring System (PRAMS) and vital statistics. DOH started PRAMS in June 1999 as a pilot project. The year 2000 is the first full year of PRAMS data.

An annual pace has been blueprinted to meet the Healthy People 2010 objective for this measure.

a. Last Year's Accomplishments

This measure reflects the state priority to reduce Hawaii's rate of unintended pregnancies. The 2006 data (last available) indicates 52.3% 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 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 is essential to reduce unintended pregnancy rates. Health insurance coverage can improve access to contraceptive supplies and services. While Hawaii's employer-based health insurance law does mandate health plans to provide contraceptive supplies and services, plans may offer only limited options.

Access to contraception is improved through conveniently located publicly supported family planning (FP) services. Forty clinic locations on 6 islands provided subsidized 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 Department of Health (DOH) is the only Title X grantee for Hawaii contracting with community health centers, colleges' student health services, and physicians in rural areas for subsidized FP clinical and health education (HE) services. The Title X FP program is part of the Title V agency.

Direct services are delivered by community clinics as there are no state or county operated FP clinics in Hawaii. In FFY 2007 14,416 clients were provided subsidized FP clinical services during 22,793 clinical visits: 5,439 clients made 8,359 client visits for pregnancy tests. Of these, 2,005 were positive and unplanned. The clients stated that pregnancy was due to a method failure (34%) or because no method was used (66%), demonstrating a continuing need for statewide clinical and community based HE services to prevent unintended pregnancies.

In FFY 2006, Federal government approval for an over-the-counter emergency contraception (EC) option for women over age 18 provided expanded support for EC dispensing statewide. In FFY 2007, this support included an EC website and a promotion campaign in clinics and pharmacies.

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.

Population-based services were provided through Title X's statewide FP Community HE and Information program and Mothers Care. Activities included school presentations, distribution of educational materials and posters, media initiatives such as radio public service announcements translated into 15 languages, and health fairs. The HE program made 43,287 direct contacts (individual or group sessions), of which 17,762 (41%) were males; and 508,069 indirect contacts (health fairs, exhibits, media information).

Title X also funds outreach and educational counseling services by the MAN project, to reach males most likely to engage in risky sexual behaviors, including incarcerated youth and those attending alternative schools for at-risk youth.

The 2007 State Legislature appropriated \$1.2 million for FP clinical services and \$463,587 of Temporary Assistance to Needy Families (TANF) funds for HE to reduce out-of-wedlock pregnancies. The appropriation was made in response to efforts by FP advocates and recommendations from a private-public task force convened by the Title V agency.

The FP Program sponsored and hosted the annual reproductive health conference to increase provider knowledge and skills in new technology. Videoconference training and quarterly meetings of both clinical providers and Health Educators featured information on the revised Clinic Visit Record (CVR) and updates on contraceptive issues. The CVR revision was done with the intent of gathering more data regarding risk factors for conception (per national guidelines) and documentation of client counseling. With this data, the FPP will be able to determine key issues for HE and offer providers with technical assistance to effectively address these factors.

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. Plan for Title V and Title X needs assessment to determine the progress made on unintended pregnancy and identify strategic areas where improvement is feasible.				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 continued. Several public health web sites contain information on clinic locations for FP services, contraceptive methods, reproductive health services for men and FP health educator contacts.

The \$1.7 million appropriated by the Legislature for FP services is administered by the Title V FP program (FPP). The funds were used to contract FP clinical services. The TANF portion was used to increase health educator staffing statewide. With these funds, the FPP was able to contract with a community health center (Waianae Coast Comprehensive Health Center) located in a high poverty area with a large Native Hawaiian population, thus, expanding services to high risk clients in this underserved community.

The FPP held two reproductive health trainings and a two-day conference to increase provider knowledge and skills.

Title V Women's Health program convened the Women's Health Week Committee, comprised of numerous community partners, to disseminate public service 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 appeared on bus placards, all government pay stubs and included radio messages translated into several languages, proclamations, and e-grams.

c. Plan for the Coming Year

The 2007 data will be reported next year. Objectives have been set to decrease by 1 percentage point per year.

FP services will continue to monitor contract sites and provide technical support. The FPP will continue to assure that clients in strategic geographical areas have access to services.

The FP Health Education program will continue to collaborate with other department and community-based partnerships on the benefits of abstinence, delaying sexual intercourse, contraception options, and importance of 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.

The Male Achievement Network (MAN) Project offered through the Waikiki Health Center (WHC) will continue to promote healthy reproductive decisions and use of contraception including condom use to men. WHC is exploring federal grant funding opportunities to continue support for the MAN program.

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 from client visit records will be analyzed to improve service delivery. Joint trainings/meetings are planned for the clinical providers and health educators to improve collaboration, service delivery, and access to services among the FPP contractors.

Data on unintended pregnancy using PRAMS and Vital Statistics will be collected. Efforts to conduct more complex analysis of PRAMS unintendedness data are hampered by the vacancy of the coordinator position. Recruitment will continue.

Healthy Youth Hawaii (HYH), formerly known as the Hawaii Teen Pregnancy Prevention and Parenting Council, will sponsor a teen pregnancy prevention summit in October 2008. DOH will continue its membership and support HYH's new goal to promote the use of evidence-based, culturally appropriate teen pregnancy/STI/HIV prevention and sexuality health education programs for Hawaii's youth.

The Title V Women's Health program is working with key partners to plan a Perinatal Health Summit in October 2008 to improve access to quality preconception and perinatal health. The conference is being held on the island of Hawaii as there are disparity issues being addressed through community-based consortia in the County as part of the federal Healthy Start Perinatal Disparities Program. This location will allow for others statewide to learn about the unique accomplishments and challenges faced by neighbor island programs through presentations and discussion opportunities provided.

Work on the Title V needs assessment will begin in late 2008; while the Title X needs assessment

will be completed in 2009. Efforts will be made to coordinate use of data and stakeholder input for both assessments.

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	2003	2004	2005	2006	2007
Annual Performance Objective				70	70
Annual Indicator		62.7	71.4	62.7	71.9
Numerator		37	50	37	41
Denominator		59	70	59	57
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	72	74	76	78	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.

Notes - 2005

This is a new State Performance Measure added in for the 5-year reporting period, FY 2006-2010.

a. Last Year's Accomplishments

The 2007 indicator was 71.9%. The objective was met. Data for CY 2007 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 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.

The DOH Newborn Hearing Screening Program (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 Early Intervention (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.

In 2007, EI care coordinators verified that they are obtaining consents from families to allow exchange of information with NHSP. Initial steps were taken to add consent status fields on Part C related databases to facilitate electronic matching with the state's Early Hearing Detection and Intervention (EHDI) database. This is expected to improve documentation related to the percentage of infants with hearing loss who are receiving EI services by age 6 months.

The DOH Early Intervention Section (EIS) provides EI services for children under three years of age with special needs. Children who have developmental delays or are at risk of delays are eligible for services in Hawaii. This includes children with any type, degree or laterality of permanent hearing loss.

In 2007, NHSP and EIS continued to collaborate with the American Academy of Pediatrics-Hawaii Chapter EHDI Champion to arrange educational training for pediatricians, speech pathologists, audiologists, social workers, public health nurses, and other providers.

The 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, the 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 2007, the lending libraries were expanded. The hearing aid and FM system loaner banks were also expanded.

Ohana Time informational family support meetings continued during 2007. 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 - Hawaii (Baby HEARS-Hawaii) project supported the CSHNB/NHSP efforts to improve newborn hearing screening and follow-up during 2007.

Preliminary 2007 data analysis shows that 60 infants were diagnosed with permanent hearing loss, but 3 moved out of state soon after diagnosis. Of the remaining 57 infants, 41 received EI before 6 months of age, 6 received EI after 6 months of age, 3 were lost to documentation and 7 families refused services. Families who refuse may contact EIS at any time before their child's third birthday if they later decide they want services.

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 understanding of hearing loss and early intervention/other services.				X
9. Monitor/track audiological evaluations results, hearing, amplification, and early intervention enrollment.				X
10.				

b. Current Activities

EIS provides EI services such as audiological evaluations and hearing aid related services for infants with permanent hearing loss. Part C EI funds are not used to purchase hearing aids, but EIS has a procedure for supporting purchase of hearing aids with state funds upon family request. The 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.

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 <http://health.gov/family-child-health/eis/nhsp.html>. The "Sound Steps Hawaii State Resource Guide for Families of Children with Hearing Loss" has been developed and is being disseminated to EI programs and audiologists.

EI Hearing Specialist is providing consultation and services for children under 3 years with hearing loss, their families, Individual Family Support Plan teams and transition teams statewide. Ohana Time information family support meetings, the Deaf Mentor project and Ohana Sign classes continue.

The EHDI Advisory Committee met in November 2007 and gave input on draft policies, procedures and manuals, including the "Sound Steps" family resource guide.

Activities are supported by the Baby HEARS-Hawaii follow-up grant, Part C grant, and state funds.

c. Plan for the Coming Year

The target for this objective has been set to increase by 2 percentage points annually. Although the objective was met in 2007, data is preliminary. Once data is finalized, consideration will be given to changing activities if necessary.

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 contractual Deaf Educators will provide consultation and services for children under 3 years with hearing loss, their families, Individual Family Support Plan teams and transition teams statewide. The Deaf Mentor project and Ohana Sign classes will continue. Collaboration with Cochlear Implant centers, the Hawaii Center for the Deaf and the Blind, the Gallaudet University Regional Center, and the Deaf-Blind Project will continue.

The Baby HEARS-Hawaii grant project ended in March 2008. NHSP has been awarded a 3 year continuation grant which began April 2008. Through the Baby HEARS follow-up project, a part-time Parent Coordinator will be hired 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.

The EHDI Advisory Committee and its subcommittees will continue to meet and provide input on state program policies and procedures.

Activities will be supported by the Baby HEARS-Hawaii follow-up grant, Part C grant, and state funds.

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	2003	2004	2005	2006	2007
Annual Performance Objective				13	12
Annual Indicator		13.2	13.5	13.5	15.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	12	11	11	11	11

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).

Notes - 2005

The data comes from the Hawai'i Youth Risk behavior Survey (YRBS). The 2001 and 2003 survey sample did not meet the CDC requirements for population-based weighting of the data. Thus, 2001 and 2003 results are unweighted and apply only to students participating in the survey and not the general population of public high school students in the state. The 2001 and 2003 data is not comparable to the 1999 weighted data. The numerator and denominator reflect

the actual sample results. The survey is conducted every two years. The 2003 data is the latest available.

a. Last Year's Accomplishments

This measure reflects the state MCH priority to reduce rates of child overweight. The 2007 Youth Risk Behavior Survey (YRBS) data showed an increase over the 2005 rate, with 15.6% of high school youth reporting height/weight figures indicating they were obese according to Body Mass Index (BMI) charts. The difference between the 2005 and 2007 rates was not statistically significant, however, the Hawaii rate was higher than the national rate (13.0%).

The Hawaii Health Initiative (HHI) continues to be the DOH lead to increase physical activity and healthy eating among Hawai'i residents. HHI focuses on three main areas to prevent chronic diseases in Hawai'i: prevention of tobacco use, increasing physical activity, and improving nutritional habits.

Title V participated as part of a multi-disciplinary group of private and public stakeholders that developed the "Hawai'i Physical Activity and Nutrition Plan 2007 to 2012" in August 2007. The report includes a broad range of strategies to improve physical activity and nutrition among Hawai'i residents.

HHI formed a statewide Physical Activity and Nutrition (PAN) Coalition that developed working objectives now being reviewed for implementation by county PAN coalitions. Title V staff participate in several of the work groups.

HHI sponsored a special video category in a statewide youth video competition. Students from kindergarten to grade 12 created public service announcements (PSAs) designed to influence their peers to be more active and eat more fruits and vegetables. The competition included public, charter, private and home schools within the state.

In 2006, the Secretary of Health & Human Services presented HHI with the Innovation in Prevention Award for creative approaches to health promotion and chronic disease prevention that are making a difference in the public sector.

The DOH and Honolulu Theatre for Youth (HTY) formed a new partnership to promote physical activity through "Sport," an interactive, physical comedy play. The performance integrates messages on physical activity from HHI's Start Living Healthy media campaign.

The Community Grocery Store Project is a pilot program of DOH's health education campaign. DOH is partnering with grocery stores throughout the state to promote consumption of more fruit and vegetables using store displays, cooking demonstrations, and presentations by farmers.

WIC continued to provide nutrition counseling and food coupons to low-income pregnant women and families with young children. The Child BMI Wheel, designed for use by health care professionals continued to be distributed statewide. The primary care contracts continue to collect BMI on uninsured children above 2 years of age for early identification and referral of overweight children.

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 expert 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). Trainings are being conducted on the

toolkit for pediatric providers statewide.

HHI funded a Walkable Communities position to pursue policies for healthier community design. A DOH Healthy Built Environment work group was convened which drafted agency testimony to support state pedestrian/bicycle infrastructure development. Community trainings were conducted to assist neighborhoods to assess and develop recommendations to make their neighborhoods more walkable. HHI is also sponsored Active Living by Design (ALD) consultant, Mark Fenton, to review Hawaii Island community development plans to include more pedestrian/bicycle infrastructure codes and policies. Mr. Fenton has also conducted ALD trainings with the local development community and provided the keynote address at the statewide PAN Summit.

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 PAN 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

Title V continues to address the physical activity and nutrition issues in partnership with the Coordinated School Health Program (CSHP). The CSHP continues to strengthen infrastructure by improving decision-making, communication, expertise and resource support around school health.

In February 2008, Title V sponsored a training on the Pediatric Weight Management Toolkit for primary care health center providers, EPSDT and MCHB coordinators.

State and neighbor island PAN coalitions continue to promote healthy food choices and lifelong physical activity through implementation of the state PAN Plan.

Department of Education (DOE) announced its new Wellness Guidelines that includes standards for food sold or provided on campus, nutrition education, physical education and activity 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 requires all school food authorities that participate in the National Lunch Program to establish and implement wellness policies to promote healthy schools.

The Walkable Communities program partnered with AARP to conduct walk audits of the state's 50 most dangerous intersections. The recommendations were used to support installation of new traffic signals for several counties and the passage of funding for a statewide pedestrian safety program.

Surveillance activities continue through the 2007 YRBS to provide obesity related data for youth.

c. Plan for the Coming Year

State objectives have been set to decrease 1% point every 2 years.

HHI will implement the USDA Food Stamp Nutrition Education Network program in Hawaii. The federal reimbursement program will provide expanded funding to programs providing nutrition education to those individuals eligible for Food Stamp benefits.

The WIC food voucher program will be adding fruits and vegetables and whole grain bread to their population's food choices.

The DOH/DOE survey committee will continue to monitor the perceptions of young people ages 11 to 17 on their physical activity, weight and nutrition through the bi-annual Youth Risk Behavioral Survey (YRBS).

HHI will continue efforts to maintain state and national coalition ties to promote healthy food choices and lifelong physical activity. The PAN Coalition will be responsible to ensure the implementation of Hawaii's PAN Plan.

The DOE in partnership with HHI will continue to implement its new Wellness Guidelines. The document is one of the most comprehensive in the U.S. and was developed in partnership with DOH and a diverse group of stakeholders. Policies include a prohibition on the sale of any product that lists sugar as its primary ingredient. This means school fundraisers, which often include the sale of candy or cookies, will have to change. Schools will be allowed to select components of the guidelines to implement each year over a four-year rollout plan. DOE requires all components of the guidelines be in place by June 2011.

Training is being provided for school teams that will help implement the Wellness Guidelines. The State is also planning a summer workshop for businesses which provide fundraiser options for schools. Businesses will gain in-depth knowledge of fundraising nutrition guidelines and have the option to work with wellness staff on reformulating recipes and introducing new products.

The HHI ended funding for the Walkable Communities position in DOH, but is continuing its work on promoting a healthy built environment with current staff. Active Living by Design training of trainers was completed. Local trainers are now conducting community presentations on the neighbor islands.

The state Department of Transportation (DOT) awarded its 1st round of Safe Routes to School

(SRTS) community grants in June 2008. The federally funded program provides \$1M annually to the state to promote walking/bicycling to school to address increasing rates of child obesity. Title V provided technical assistance to the HI Bicycling League for their SRTS grant to expand its nationally recognized Bike Ed program in the schools. DOT is expected to announce its 2nd round of SRTS grant funding in Fall 2008.

DOT develop a statewide pedestrian plan and will also be updating the state Bike Plan. The City of Honolulu is also currently updating its Master Bicycle Plan. DOH will partner with community advocates to work with city officials to implement a new city charter amendment to make Honolulu a pedestrian/bike-friendly city.

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	2003	2004	2005	2006	2007
Annual Performance Objective				12	11
Annual Indicator	12	12	12.3	12.3	12.3
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	11	10	10	10	10

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.

Notes - 2005

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. Results from the 2005 survey are pending release and will be provided in next year's report. Objectives are based on 2003 data and are set to decrease 1% every 2 years.

a. Last Year's Accomplishments

This measure reflects the state's MCH priority to reduce underage drinking. The 2005 Youth Risk Behavior Survey (YRBS) middle school data showed 12.3% 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. The 2007 YRBS middle school data will be released later in 2008. There is no comparative data for national middle school YRBS. Hawaii is close to meeting the Healthy People 2010 objective of 11% (for alcohol and illicit drugs).

In the Department of Health (DOH), the Alcohol and Drug Abuse division (ADAD) is the lead in addressing underage drinking (UD). ADAD provides funding support to the Hawaii Partnerships to Prevent Underage Drinking (HPPUD) Coalition. HPPUD continues to lead the collaborative efforts to prevent underage drinking. Title V serves on the HPPUD public awareness and media committee providing YRBS data, information on health risks related to UD, and stressing the importance of prevention and education efforts.

In April 2007, Anheuser Busch presented a \$240,000 grant to the State to extend the University of Hawaii Alcohol Project to combat underage and binge drinking on campus. Hickam Air Force Base (HAFB) was awarded a 3-year, \$950,000 grant to reduce underage drinking for persons serving in the U.S. Air Force. The program is now in its second year of funding.

Adults continue to remain the primary alcohol source for underage youth. The Cancer Research Center, Honolulu Police Department (HPD) and the Liquor Commission continued to collaborate on enforcement efforts such as sting operations at retail liquor outlets to arrest adults who purchase liquor for youth or retailers that sell liquor to underage youth. Training efforts between civilian and military enforcement personnel have broadened these sting and "shoulder tap" operations from civilian retailers to the military establishments.

The Honolulu Liquor commission's work has increased their prevention efforts, coordinating the educational outreach project "Shattered Dreams" in high schools and placing anti-drinking posters on City the buses. The first annual HPPUD Conference, was held in April 2007, bringing together the neighbor island HPPUD coalitions to discuss enforcement and prevention activities as well as future actions statewide.

MADD continued to conduct training for high school students to do presentations on an alcohol prevention curriculum to elementary school aged children.

The Lt. Governor (LG) remains one of the co-chairs of the national "Leadership to Keep Children Alcohol Free" organization, established to prevent the use of alcohol by children ages 9 to 15. The LG's Office continues to provide leadership in coordinating and publicizing statewide underage drinking activities and finalizing the state underage drinking action plan through HPPUD in conjunction with key community stakeholders.

The HPPUD Coalition continued to pursue legislation to strengthen underage drinking laws and support primary prevention programs statewide such as the ignition interlock bill.

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 through 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			X	X

underage drinking.				
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.				
10.				

b. Current Activities

The Title V program continues to participate in the HPPUD Coalition, whose goal is to change prevailing norms/attitudes that accept UD.

The military conducts stings on alcohol sales to minors on their bases, such as those conducted by HPD and the Honolulu Liquor Commission. MADD continues to train high school students to present an alcohol prevention curriculum to elementary school aged children.

The Hawaii National Guard, the Attorney General's office and HPPUD continue to partner on activities including public service announcements and Teach-Ins, which engage student athletes to speak to their peers. HPPUD and HPD continue advocacy efforts to pursue legislation to strengthen UD laws and support prevention programs.

The 2nd annual HPPUD Conference was held in Kailua-Kona in April 2008, bringing together the neighbor island HPPUD coalitions to discuss enforcement and prevention activities.

The LG's office continues to provide leadership in coordinating and publicizing statewide UD activities. Eleven UD Town Hall meetings were hosted by various communities with small grants. Meetings on Hickam Air Force Base were mandatory for all underage military personnel.

Title V with the DOH/DOE Survey Committee (DDSC) continues to assist with the implementation of the YRBS and substance use school surveys.

In 2008, Hawaii became the 47th state to enact an ignition-interlock law which will monitor drivers who operate a motor vehicle under the influence of alcohol or drugs or both.

c. Plan for the Coming Year

YRBS data for this measure will be updated in next year's report. State objectives have been set to decrease 1% point every 2 years.

The Title V program will continue to actively participate in the Hawaii Partnerships to Prevent Underage Drinking (HPPUD) Coalition. With the involvement of the Hawaii National Guard, it is anticipated there will be increased outreach and participation with the various military bases which will strengthen the existing partnership in the prevention of underage drinking.

HPPUD will continue to coordinate media activities to raise awareness about UD and related laws including the social host liability law targeting parents/adults that host activities serving alcohol to

minors. The goal is to change prevailing norms/attitudes that accept UD.

Quarterly video conference meetings with the neighbor island HPPUD coalitions are being planned to improve statewide coordination. In addition, an interactive website will be developed to list prevention activities during anticipated times of increased underage drinking periods (such as high school and college graduations).

The AG's office will continue working through HPPUD on activities including public service announcements and Teach-Ins, which engage student athletes to speak about the adverse effects of alcohol to their peers. Under the leadership of HPD, HPPUD will continue advocacy efforts to pursue legislation that strengthen underage drinking laws and support prevention programs. Securing funding to sustain program activities also remains a priority.

The Honolulu Liquor Commission will be increasing their efforts to distribute alcohol testing kits to parents who think their children are in need of counseling or rehabilitation services.

Title V with the DOH/DOE Survey Committee (DDSC) will assist the University of Hawaii contractors (the Curriculum Research & Development Group and the UH School of Psychiatry) to implement the YRBS and the substance use school surveys. The DDSC will continue to be responsible for dissemination of the 2007 YRBS data.

As part of the Title V needs assessment, YRBS data will be analyzed to determine whether adequate progress is being achieved for this priority issue particularly among disparate populations of youth. Title V is seeking technical assistance for epidemiological analysis of the YRBS. Plans are to use a portion of the federal State Systems Development Initiative funding to secure support.

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	2003	2004	2005	2006	2007
Annual Performance Objective				73.4	71.4
Annual Indicator		74.5	73.6	74.4	72.1
Numerator		4477	4626	5183	4445
Denominator		6010	6285	6967	6165
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	70.7	70	69.3	68.6	67.9

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.

Notes - 2005

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 2007 data indicates 72.1% of Hawaii's children 6-8 years have experience with dental caries. The state objective of 71.4% 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 5 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.

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 fluoride rinse, topical fluoride, proper tooth brushing and flossing instruction to school age children statewide. Dental Certificates are being provided to dentists to issue to school aged children whenever their dental treatment are completed. Parents are encouraged to present the certificates to their child's school.

DHD currently has a pilot project on Molokai collaborating with the pharmacy to analyze the number of fluoride refills that were dispensed to families compared to the number of initial prescriptions filled. The pharmacist monitors and reminds families when refills are due. Pharmacy records indicate that the prescription and refill rate have doubled. Partnerships with physicians, midwives, public health nurses, WIC and the primary care health center along with incentives and repeated consistent messages has produced positive results.

An educational brochure to promote the \$500 credit for dental evaluation and cleaning for pregnant women is being developed for Perinatal and WIC providers to encourage the use of this

recent benefit. This will indirectly improve the oral health of young children. Community Case Management Corporation, contracted by the Medicaid agency, will also assist in informing pregnant women about this subsidy.

A training curriculum for fluoride varnish is also being developed for use by EPSDT and Medicaid providers.

Refer to the NPM 09 narrative for other current year activities addressing children's oral health.

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 will be essential to identify key issues and strategies to improve the oral health of children as part of the Title V needs assessment process. Needs assessment activities are scheduled to begin in late 2008.

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 under 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. Efforts will be made to have oral health education included in all population-based programs for perinatal clients and advocate for dental care to be included in all health insurance coverage for pregnant women. This prevention effort and education needs to continue with the parents of the 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 Hawaii '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.

Title V will convene key stakeholders to discuss implementing strategies to improve children's oral health identified through the Title V needs assessment process. Strategies identified include reinstating the policy for each child entering school to have a dental health certificate and establishing a curriculum to train health care professionals on the importance of children's oral health and provide helpful information to parents.

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	2003	2004	2005	2006	2007
Annual Performance Objective				25	24.1
Annual Indicator		32.6	26.9	28.8	27.5
Numerator		1259	1045	1129	1073
Denominator		38600	38805	39257	39007

Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	23.6	23.2	22.7	22.2	21.8

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.

Notes - 2005

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. Bureau of the Census, Population Estimates Program, SC-EST2005-AGESEX_RES: Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2005., released August 4, 2006.

a. Last Year's Accomplishments

This measure reflects the State priority to reduce adolescent chlamydia. It was selected due to a steady increase in adolescent chlamydia since 1998. The 2007 provisional data indicates a chlamydia case rate of 27.5 for 15-19 year olds per 1,000 females. The objective was not met. Relative to national standards, Hawaii's rate is comparable. In 2006 (latest available national data) the U.S. rate for 15-19 year olds was 28.6 per 1,000 compared to 28.3 for Hawaii.

The HP 2010 objective is to reduce chlamydia infections among females aged 15-24 years attending family planning clinics and STD clinics to 3.0%. The Hawaii rate for 2006 was 9.0%, thus the objective was not met.

Title V continues to oversee 12 Perinatal Support Service contracts, the federal Healthy Start Perinatal Disparities project in Hawaii County, and 3 Baby S.A.F.E. contracts that provide STD preventive education and referrals.

The Hawaii TeenLine and website provided STD information for Teen Pregnancy Prevention Month and quiz questions to help educate teens on sexual activity and STD prevention. The DOH STD Prevention Program (SPP) and Family Planning program (FPP) websites provide STD information and list healthcare providers offering free/low-cost STD services for the uninsured.

According to SPP, chlamydia is the most prevalent reported STD in Hawaii. An article in one of Honolulu's major newspapers stressed the importance of screening and treatment for STDs and how to find services. The article addressed the confusion among many consumers regarding the different types of screening tests.

The Title V Women's Health Section coordinated the development and distribution of 70,000 women's health screening guides for Women's Health Week, which included chlamydia testing recommendations. WHS also participated on the DOH HPV meetings to coordinate dissemination of information on the vaccine to prevent cervical cancer for girls and women.

Hawaii representatives from FFP, SPP, and the state laboratory participated in the CDC Regional Infertility Prevention Project (IPP) to improve screening, timely client and partner treatment, and use of optimal testing. A Tri-Regional meeting was held to discuss successful strategies to increase expedited partner therapy, re-testing positive chlamydia clients, and screening among disparate populations.

Train-the-trainer instruction was offered on 2 curriculums addressing adolescent pregnancy and STD prevention: "Be Proud, Be Responsible" and "Making Proud Choices." A two-day conference, Teen Intimacy Issues, addressed internal and environmental challenges to safer choices for teens.

The Adolescent Chlamydia Work Group (ACW) facilitated by FPP met every 2 months with representatives from DOH, DOE, youth providers, ACOG, health insurers and the university. Two major goals are: 1) increasing condom use among teens; and 2) increasing screening and treatment. ACW commissioned a report for a literature review of programs designed to promote condom use among 15-19 year olds using social marketing techniques. Few evidence-based programs were identified. Use of youth-oriented media (You Tube, My Space, text messaging) and school based approaches were suggested as outreach strategies.

Other activities included clarifying insurance coverage for chlamydia screening and reviewing HEDIS data on chlamydia screening rates for the state's major insurance plans, including Medicaid. New sexual health survey questions for the 2007 Youth Risk Behavior Survey (YRBS) were identified to help monitor progress and assist with planning efforts.

Information to support increased funding for the DOH SPP to maintain the statewide chlamydia screening program. ACW members were advised to contact their legislators and key committee members to support the request. The SPP received an additional \$122,000 from the Legislature (half of the amount requested); however, this marks the first funding increase received by the program in 12 years. Funds were used for STD screening and professional training. The ACW also supported a bill to require recipients of state funding for sexual health to provide medically accurate, factually information that is age appropriate. The bill was held in committee.

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			

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

The DOH STD Prevention Program (SPP) conducted a statewide healthcare provider survey to identify training needs and perceived barriers to provide chlamydia screening and treatment.

The state's largest health insurer (HMSA) made increasing chlamydia screening rates one of its program priorities. HMSA developed a provider toolkit on chlamydia with information about insurance coverage, ideas on how to take action, screening/treatment guidelines, tips on taking sexual histories, and fact sheets for providers and patients.

A clinicians STD update conference, grand rounds at 7 sites, and a partner management training reached approximately 300 healthcare professions.

The DOH Communicable Disease Division (CDD) Chief met with the Board of Medical Examiners (BME) to discuss implementing expedited partner therapy (EPT) without a visit for partners exposed to chlamydia. The BME reviews and approves medical practices in Hawaii. The decision was tabled due to liability concerns.

Non-profit agencies interested in adolescent health were invited to discuss the condom social marketing report findings. The intent was to identify partners to collaborate with DOH on a planning grant for implementation. Several agencies were interested but could not commit to writing the grant proposal.

A presentation on chlamydia was well-received at a meeting of the Keiki Caucus (comprised of agencies and legislators interested in children's issues). Interest to support future legislation was expressed.

c. Plan for the Coming Year

Provisional 2006 data will be updated. State objectives are set to decrease 2% annually.

The DOH STD Prevention Program (SPP) continues to provide direct services for chlamydia screening and treatment at its Oahu clinic and Juvenile Detention Center. SPP is also working to integrate provision of STD services on the neighbor islands utilizing HIV counselors and testers. Statewide partner notification services are available to locate partners of clients with positive test results. Partner treatment is an important strategy to reduce the incidence of chlamydia.

On-going chlamydia screening and treatment services are available on 6 major islands through SPP and the DOH Family Planning Program (FPP) agreement. New FPP contracts with community health centers, private agencies and doctors, and colleges for clinical services include STD screening and treatment at 42 sites. The FPP continues to contract for family planning and STD/HIV education offered to schools, the community, and through health agencies. Additional funding appropriated by the 2007 Legislature will be used to increase the number of full-time health educators. Educators are using creative ways to encourage at risk populations to seek family planning services, including STD screening.

Title V continues to oversee Perinatal Support Services and Baby SAFE contracts, the Perinatal Disparities Project that provide access to STD preventive education and referrals.

Preliminary data from the provider survey indicate barriers to providing chlamydia screening among adolescents include: difficulty addressing sexual issues, lack of insurance/reimbursement, lack of office staff, reduced access to screening, issue of confidentiality (parents accompany adolescent), and difficulty with initially getting adolescents in for visits and compliance with follow-up. Survey findings will be shared with various health plans and used to develop strategies to increase screening by working with provider networks.

Region IX IPP activities will continue including efforts to decrease chlamydia and gonorrhea positivity in racial/ethnic minority groups. More emphasis is being placed on conducting urine chlamydia screening at the same time women seek pregnancy tests and emergency contraception since these clients are at risk for chlamydia. Expedited partner therapy is also being stressed as an important strategy to reduce reinfections.

ACW will disseminate a survey to youth serving organizations to identify programs that contribute to reducing adolescent chlamydia and other STDs. The latest YRBS results indicate that Hawaii teens have high rates for delaying sexual intercourse, however have low rates of condom use among those students who are sexually active.

ACW will continue to explore possible funding opportunities to implement social marketing activities to encourage greater condom use among teens. Marketing faculty from the University of Hawai'i will be assisting with development of an initial planning grant.

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	2003	2004	2005	2006	2007
Annual Performance Objective				8	7.6
Annual Indicator	9.3	8.1	8.4	9.4	9.4
Numerator	1625	1420	1440	1716	1716
Denominator	17381	17633	17233	18300	18300
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012

Annual Performance Objective	7.2	6.8	6.5	6.2	5.9
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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.

Notes - 2005

This is a new State Performance Measure added in for the five-year report period, FY 2006-2010.

Data for this measure comes from the Hawai'i Pregnancy Risk Assessment Monitoring System (PRAMS) and vital statistics. 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 2003 is the latest 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 and is responsible for 5% of all perinatal deaths. The 2006 data (latest available data) indicates 9.4% of pregnant women reported smoking during pregnancy. The state objective was not met.

The percentage of women who report smoking during pregnancy has remained stable over the past 5 years. Hawaii's prevalence rate compares well to other PRAMS states that range from 6.8% to 25.3% (2002 data).

In July 2007, Title V Perinatal Support Services (PSS) contracts were modified to include specific language to address smoking in the perinatal period. PSS providers continue to use Brief Intervention counseling techniques to increase tobacco cessation during pregnancy. PSS client data forms were also revised to include reporting on smoking behaviors.

The PSS advocacy and training contract was awarded to Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii that also began in July 2007. HMHB provided ongoing smoking brief intervention training and maintained a phone line and website that includes smoking cessation resources. HMHB also participated in the Prenatal Smoking Workgroup convened by Title V to decrease tobacco use in the population.

The Hawaii County Perinatal Health Disparities Program services was contracted out to a community agency to serve Hawaiian, Other Pacific Islander, Hispanic and adolescents during pregnancy and two years during the interconception period. Clients are screened for risk behaviors and provided intervention services for those women who smoke. Specific language to address smoking, in the perinatal and interconception periods, was included in service contracts that began in October 2007. The same form developed for PSS is being utilized to capture smoking data. The program is funded by a federal Healthy Start grant.

The Baby Substance Abuse Free Environment (Baby S.A.F.E.) program for substance-using

pregnant women provided education and smoking brief intervention counseling for individual clients. The importance of smoking cessation during pregnancy is also covered in group health education classes. Information is provided as part of outreach activities like community health fairs. Baby S.A.F.E. providers have used smoking brief intervention screens on pregnant women to initiate discussion and screen for other substance abuse problems when conducting outreach for Baby S.A.F.E. pretreatment services.

The WIC program screens clients for smoking during pregnancy and makes referrals for further assistance at the initial client visits using a health questionnaire.

Title V participated in the March of Dimes Hawaii Chapter 3rd Annual Prematurity Awareness Summit. Information was presented on the Neonatal Intensive Care support program and the importance of preconception care in addressing preterm birth. Research showing smoking during pregnancy has been a contributing factor for preterm and low-birth weight was also discussed.

The Pregnancy Risk Assessment Monitoring System (PRAMS) collected population based data on smoking behavior during pregnancy and provides the data for this measure. Although the PRAMS Coordinator position is vacant again, the Hawaii survey managed to maintain a 70% response rate, the minimum required by the CDC for a valid dataset.

Title V worked closely with providers and stakeholders to address smoking cessation interventions during and after pregnancy. A Prenatal Smoking Workgroup was formed to address this issue. The work group met quarterly, identifying legislative strategies, reviewing data, improving collaboration between programs, and identifying potential projects.

Tobacco prevention and control programs continued aggressive media and counter-marketing initiatives targeting youth and increased public awareness on adverse effects of secondhand smoke, predatory tobacco industry tactics, and the addictive nature of tobacco. Media ads also targeted parents to consider the adverse effects of their smoking behaviors on their young children.

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

Title V programs continue to screen all high-risk pregnant women for substance use including cigarette smoking. The HMHB facilitated training for program providers on Basic Tobacco Intervention Skills certification and Basic Intervention Skills Instructor Certification training. Nine providers received certification for Basic Tobacco Cessation and two providers became certified instructors.

The Prenatal Smoking Workgroup continues to meet regularly and share promising practices for intervention to assist pregnant women to stop using tobacco. Due to the advocacy efforts of the workgroup, a resolution was introduced in the 2008 Hawaii legislature requesting the Department of Human Services to collect data and report how counseling coverage could be provided to all Medicaid beneficiaries, including pregnant women, wishing to quit smoking. The workgroup also provided expertise in assisting the PRAMS Steering Committee to select appropriate survey questions in the upcoming 2009 PRAMS survey.

HMHB used radio media messages in 11 dialects focused on pregnant women to stop smoking and also provided education to obstetrician-gynecologists regarding brief intervention and cessation resources.

The Hawaii Tobacco Quitline continues to provide free statewide telephone counseling services to all tobacco users, including pregnant women. In addition to counseling, the Quitline provides information regarding community resources available to the tobacco user to assist in tobacco cessation.

c. Plan for the Coming Year

Data for PRAMS will be updated in next year. The objectives for this measure have been set to decrease 1 percentage point every 2 years to assure progress in achieving the Healthy People 2010 objective of 1%. Title V will also address increasing smoking cessation in the preconception period and work to assure women do not resume smoking during the post-partum period.

Title V (PSS and Baby S.A.F.E) and the Hawaii County Perinatal Disparities program providers will continue service and data collection on the use of tobacco and provide program and referral interventions. Program providers will continue to conduct tobacco cessation services to high-risk pregnant women.

Title V will develop a web-based perinatal data collection system for program providers and replace the hard-copy data collection forms. Using computer technology will increase efficiency for data entry, collection and invoicing for services. Data access for analysis, program evaluation and reports will be available to perinatal program providers including prevalence rates of smoking during pregnancy and the interconception period.

The Baby S.A.F.E. purchase of service contract will be revised for the 2009 fiscal year. Costs for conducting Baby S.A.F.E. services will be determined so that motivational interviewing activities such as smoking brief intervention can be reimbursed at a unit cost rate. The contracted services will continue to provide outreach, assessment/screening for early identification of substance use,

education and intervention for tobacco cessation through its individual and group support services. Title V will oversee the follow-up support for the Motivational Enhancement Services Training (Motivational Interviewing) to program providers. The follow-up will address provider needs/issues to support improved service delivery.

The HMHB will continue to provide training of perinatal program providers on smoking brief intervention to reduce the rate of smoking during pregnancy and advocate for legislative bills aimed toward this focus. HMHB will also coordinate and assist Title V in planning for the Perinatal Summit in October 2008 that will address various perinatal topics including issues related to smoking during pregnancy.

The Prenatal Smoking Work Group plans to explore the feasibility of expanding the Hawaii Tobacco Quitline specifically to help pregnant women increase their chances to quit smoking and remain tobacco-free after the baby is born. Another promising practice that the group would like to explore is the use of a carbon monoxide breathalyzer to monitor smoking cessation efforts of pregnant women attending WIC Clinics. Pregnant smokers that show decreased carbon monoxide levels would receive free diapers as an incentive to quit smoking during pregnancy and to remain smoke-free after delivery.

WIC will also continue using their health questionnaire as an initial client assessment 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	2003	2004	2005	2006	2007
Annual Performance Objective				4.2	4.2
Annual Indicator	4.3	6.3	4.4	6.0	6.0
Numerator	755	1101	755	1089	1089
Denominator	17471	17530	17249	18130	18130
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	4.1	4.1	4	4	3.9

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.

Notes - 2005

This is a new State Performance Measure added in for the five-year report period, FY 2006-2010.

Data for this measure comes from the Hawai'i Pregnancy Risk Assessment Monitoring System (PRAMS) and vital statistics. 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 2003 is the latest 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 prenatally exposed. Data comes from the Pregnancy Risk Assessment Monitoring System (PRAMS). The 2006 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%).

Efforts focused on support services for maternal health in the perinatal period continued. Title V oversees contracts to provide Perinatal Support Services (PSS) to high-risk women statewide. The women were assessed for psychosocial risks such as alcohol use. Title V contracts Baby S.A.F.E. (Substance Abuse Free Environment) program services to provide outreach, screening, and assessment of substance using pregnant women. Clients are provided pretreatment services and referral for drug intervention services. Baby S.A.F.E. programs are located on Oahu (Waianae), Maui Island, and Hawaii Island. The DOH Alcohol & Drug Abuse Division (ADAD) funds a Baby S.A.F.E. program on the Island of Kauai.

The Hawaii County Perinatal Health Disparities Project, funded by a federal Healthy Start Grant, provided support services to high risk pregnant women focusing on the Hawaiian, Hispanic, Pacific Islander and adolescent population groups. Family Support Services of West Hawaii (FSSWH) was contracted to provide services for the program. The FSSWH staff received training in June 2007 from Dr. Ira Chasnoff of the Children's Research Triangle, to screen for Fetal Alcohol Syndrome and other substance abuse. The FSSWH staff was also trained to receive and triage referrals of positive screens to area substance abuse intervention services.

Dr. Chasnoff's training and consultation will be extended to Hawaii County physicians, social service agency staff, and other professionals as part of a two year grant received by the Good Beginnings Alliance to develop a comprehensive substance abuse screening, response and referral system on the Big Island.

The WIC program screens clients for alcohol use during pregnancy and makes referrals for further assistance at the initial client visits using a health questionnaire.

Title V contracted with Healthy Mothers, Healthy Babies Coalition of Hawaii (HMHB) to conduct perinatal advocacy, needs assessment and facilitate training of Title V perinatal providers. The contract to maintain the information and referral phone line and website was also awarded to HMHB. Women can easily access pregnancy-related health information from these sources including information on the risk of using alcohol during pregnancy.

The Fetal Alcohol Spectrum Disorder (FASD) coordinator position, funded by the 2006 Legislature, was established in 2007 in the Department of Health (DOH) under the Title V program. The FASD coordinator is responsible for facilitating the development and implementation of a comprehensive, statewide system of care for the prevention, identification, surveillance, and treatment of fetal alcohol spectrum disorders.

The Perinatal Addiction Treatment of Hawaii (PATH) program was also funded by the 2006 Legislature and commenced services in April 2007. The PATH Clinic provided 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 addressing risk factors for alcohol and other substances.	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, website); and, perinatal support provider education and training.		X	X	X
6. Advocate for policies/programs that support treatment for drug-addicted mother.				X
7. Sponsor training on smoking cessation interventions and substance use and parenting for perinatal service providers.		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

Title V continues to administer contracts and collect data for all the perinatal support programs that target pregnant women with high-risk factors including alcohol use. The FSSWH staff makes referrals for women screened positive for substance use to appropriate substance abuse treatment and intervention services.

The FASD Coordinator is implementing a pilot project to screen children for FASD enrolled in the Hawaii Healthy Start Programs. The FASD program sponsored four trainings on FASD by Dr. Laurie Seaver, a Medical Geneticist, for DOH staff and community providers. In July, the Title V and FASD program will co-sponsor a conference with Dr. Ira Chasnoff as the keynote speaker titled, "The Nature of Nurture: Drugs, Alcohol, Pregnancy, and Parenting." A new FASD informational brochure has been developed for distribution.

The FASD Task Force convened in early 2008 and has continued to meet. The Task Force identified three foci: creating a multi-disciplinary FASD clinic that would provide assessments and diagnosis, identify curricula for use with high risk youth, and identify opportunities to screen children for FASD.

The PATH Clinic continues comprehensive services to pregnant women with addiction problems (including alcohol) and has provided drug intervention services for approximately 80 women since commencing services.

The PRAMS survey continues to collect population based data on behaviors in pregnancy

including alcohol use and WIC continues to screen participants.

c. Plan for the Coming Year

The 2007 PRAMS data will be updated in next year's report. Objectives were set to decrease by 0.1% point every 2 years.

Title V will provide training opportunities to service providers to improve their ability to screen and intervene on alcohol use during pregnancy and to build infrastructure in Hawaii County. A Perinatal Summit slated for October 2008 will be held in Hawaii County and will include topics to address substance use such as the effects of alcohol use in the preconception period and during pregnancy. Data on substance use will be presented to inform perinatal program planning, evaluation, and policy development. HMHB has been contracted by Title V to coordinate planning for the Summit.

The scope of services for the Baby S.A.F.E. program will be revised for the 2009 service contracting process. The contracted services will be inclusive of all substance use (including alcohol use) and will require a data collection/payment service system to better evaluate and monitor program activities. Also, the Baby S.A.F.E. program evaluation will be completed in fiscal year 2009.

Title V will take a leadership role with Perinatal Support Service (PSS) providers to develop and implement a web-based data collection system that will generate a payable invoice according to the unit rate of each report form submitted. A web-based system will reduce the burden of mailing and storing of forms and increase efficiency. The PSS and Baby S.A.F.E. programs along with the Hawaii County Perinatal Disparities project will continue to collect data on high-risk factors during pregnancy including all substance use.

The FASD Coordinator, with support from the Task Force, will finalize and work on the three identified goals to: plan for a multidisciplinary diagnostic team/clinic; identify and implement a curriculum for high risk youth; and, institute a policy at the Department of Human Services to ensure that all children in the foster care system are screened for FASD. The FASD office will also continue to sponsor and plan for training opportunities across the system of care including medical, social services, education, legal and judiciary.

The PATH Clinic did not receive funding in the 2008 Legislative session due to the down turn in the state economy. Plans are to seek grant and foundation funding to continue comprehensive services for substance using pregnant women for the 2009 fiscal year.

The PRAMS survey questions are being revised and will be implemented by April 2009. The questions for alcohol use will remain unchanged.

The Hawaii 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	2003	2004	2005	2006	2007
Annual Performance Objective				14	18
Annual Indicator			7	14	19
Numerator			7	14	19

Denominator	28	28	28	28	28
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	21	23	24	24	24

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.

Notes - 2005

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

Children with Special Health Needs Branch (CSHNB) and Family Voices of Hawaii, with American Academy of Pediatrics (AAP)-Hawaii Chapter and University of Hawaii (UH)/School of Medicine/Department of Pediatrics, implemented the Hilopa'a Project-Integrated Systems for Children and Youth with Special Health Care Needs (CSHCN). Funding is from the MCH Bureau. The project works toward improving access for CSHCN and their families to quality, comprehensive, coordinated, and community-based systems of services, using an integrated approach to address the six core outcomes, including transition.

A Transition Planning Workbook for families of CSHCN was developed. 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.

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. Trainings include a certification process. The Rainbow Book continues to be updated as needed.

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. Speakers have included Patti Hackett with the Healthy and Ready to Work National Center (HRTW).

AAP-Hawaii Chapter has convened a Pediatric Council which includes Medical Directors of various health plans. A Council meeting focused on the transition from pediatric to adult health care, including possible transition service delivery models.

Hilopa'a Project discussed transition with physicians with combined Internal Medicine-Pediatrics training, regarding their potential roles or involvement in transition of youth to adult health care.

The Hilopa'a Project's Family Convergence 2006 conference brought more than 120 participants together, including national leaders Dr. Rich Antonelli and Patti Hackett. Sessions by family-professional teams included Successful Parent-Child-Physician Partnerships, Transitioning Into the System--Life After Early Intervention, and Transitioning Out of the System--Life After High School.

CSHNP began revising its Individual Service Plan template to include Transition Planning.

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 age 0-3 years and to families of middle-school youth prior to age 14 years.				X
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, revised policy/procedures, & transition planning with clients/families.		X		X
9.				
10.				

b. Current Activities

The Hilopa'a Project 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.

Rainbow Book trainings which include transition continue to be conducted on all islands.

Hawaii's Title V Family Trainers Academy is a new initiative of the Hawaii MCH Leadership in Education in Neurodevelopmental and Related Disabilities Program (MCH LEND), Hilopa'a Project, and Hilopa'a F2FHIC. This summer institute focuses on developing community based trainers to serve families, their professional partners, and local Community Children's Councils. Course work includes teaching others about navigating the system and transition. Trainees from all islands include parents, self-advocates, youth advocate, community programs, and pediatrician.

A youth with special health care needs is developing a Transition Planning Workbook for youth and related training.

CSHNP staff is piloting Individual Service Plans (ISP) with families. The ISP provides clarity to needs of the family and services being provided, and will integrate transition planning. Tools (based on the Hilopa'a Transition Planning Workbook) have been developed to foster discussion and assist with data collection. Increasing staff knowledge regarding transition issues is ongoing via training sessions.

c. Plan for the Coming Year

Trainings using the Transition Planning Workbook for families of youths with special health care needs will continue. A new Transition Planning Workbook for youth will be developed by a youth with special health care needs.

Rainbow Book workshops will continue to be conducted on Oahu and Neighbor Islands. A new supplement will include QUEST managed care updates.

The Hilopa'a Project is developing a pilot project to transition young women with special health care needs and disabilities to routine gynecological care. This was discussed with the Hawaii Section of the American College of Obstetricians and Gynecologists.

The Hilopa'a Project has been extended to April 2009. Activities will be sustained in various ways through the Hilopa'a Family to Family Health Information Center, UH Department of Pediatrics, AAP-Hawaii Chapter, and CSHNB.

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.

E. Health Status Indicators

The series of Health Status Indicators (HSI) provides information and helps portray the health of a population. They can assist maternal child health (MCH) programs by directing public health efforts, guiding surveillance of important MCH indicators, and providing a measure of evaluation. The data is reported on forms 20 and 21.

HSI 1A: THE PERCENT OF LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS

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 be 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//

HSI 1B: THE PERCENT OF LIVE SINGLETON BIRTHS WEIGHING LESS THAN 2,500 GRAMS

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//

HSI 2A THE PERCENT OF LIVE BIRTHS WEIGHING LESS THAN 1,500 GRAMS

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 be 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//

HSI 2B THE PERCENT OF SINGLETON LIVE BIRTHS WEIGHING LESS THAN 1,500 GRAMS
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//

HSI 3A THE DEATH RATE PER 100,000 DUE TO UNINTENTIONAL INJURIES AMONG CHILDREN AGED 14 YEARS AND YOUNGER

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).

/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//

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.

HSI 3B THE DEATH RATE PER 100,000 FROM UNINTENTIONAL INJURIES DUE TO MOTOR VEHICLE CRASHES AMONG CHILDREN AGED 14 YEARS AND YOUNGER

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//

HSI 3C THE DEATH RATE PER 100,000 FROM UNINTENTIONAL INJURIES DUE TO MOTOR VEHICLE CRASHES AMONG YOUTH AGED 15 THROUGH 24 YEARS

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//

HSI 4A THE RATE PER 100,000 OF ALL NON-FATAL INJURIES AMONG CHILDREN AGED 14 YEARS AND YOUNGER

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//

HSI 4B THE RATE PER 100,000 OF NON-FATAL INJURIES DUE TO MOTOR VEHICLE CRASHES AMONG CHILDREN AGED 14 YEARS AND YOUNGER

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.

/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//

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.

HSI 4C THE RATE PER 100,000 OF NON-FATAL INJURIES DUE TO MOTOR VEHICLE CRASHES AMONG YOUTH AGED 15 THROUGH 24 YEARS

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).

//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//

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.

HSI 5A THE RATE PER 1,000 WOMEN AGED 15 THROUGH 19 YEARS WITH A REPORTED CASE OF CHLAMYDIA

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.

//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//

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.

HSI 5B THE RATE PER 1,000 WOMEN AGED 20 THROUGH 44 YEARS WITH A REPORTED CASE OF CHLAMYDIA

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).

//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//

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.

HSI 6A/B INFANTS AND CHILDREN AGED 0 THROUGH 24 YEARS ENUMERATED BY SUB-POPULATIONS OF AGE GROUP, RACE, AND ETHNICITY

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%). 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//

Note that this measure does not reflect the large percentage of Hawaii residents that identify with more than 1 race.

HSI 7A/B LIVE BIRTHS TO WOMEN (OF ALL AGES) ENUMERATED BY MATERNAL AGE, RACE, AND ETHNICITY

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 to 19 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//

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//

Programs that target young Native Hawaiian or Other Pacific Islanders and Hispanic or Latinos should be an important focus for public health programs. Programs that ensure adequate screening in Asian mothers is important particularly due to the increased risk in pregnancy after age 35.

Note that this measure does not reflect the large percentage of Hawaii residents that identify with more than one race.

HSI 8A/B DEATHS TO INFANTS AND CHILDREN AGED 0 THROUGH 24 YEARS ENUMERATED BY AGE SUBGROUP, RACE, AND ETHNICITY

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//

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//

HSI 9A/B INFANTS AND CHILDREN AGED 0 THROUGH 19 YEARS IN MISCELLANEOUS SITUATIONS OR ENROLLED IN VARIOUS STATE PROGRAMS AND ENUMERATED BY RACE AND ETHNICITY

The determination of the demographics of children in Hawaii in various state programs could potentially identify groups that are not participating in the various state programs that could impact the health of Hawaii's children.

Overall, 15.4% of children 0-19 years of age lived in a single parent household in 2004. This varied by race and ethnicity with White (39.5%) and American Indian or Native Alaskan (31.0%) having the greatest percentages. Lower percentages were seen in the Native Hawaiian or Other Pacific Islander (13.5%) and Asian (9.7%) children. 14.6% of children living in a single parent household were not of Hispanic or Latino ethnicity, compared to 48.1% of the Hispanic or Latino children. Over-represented groups were Whites, American Indian or Native Alaskan, and Hispanic of Latino. Further evaluation into the reasons why certain groups are over represented and the impact that these differences have on the health of children is needed.

/2008/ Similar to previous year. //2008//

/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 (5.8%), and Asian (5.0%) children. 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//

Living in TANF (grant) family was found in 5.0% of all children 0-19 years of age and varied by race with white (8.2%) and Native Hawaiian or Other Pacific Islander (7.7%) having the greatest percentages of their respective populations, and Asians (0.8%) having the lowest percentage. 4.9% of children living in a TANF (grant) family were not of Hispanic or Latino ethnicity, compared to 8.4% of the Hispanic or Latino children. Over-represented groups of children were Whites, Native Hawaiian or Other Pacific Islander, and Hispanic or Latino. Further evaluation into the reasons why certain groups are over represented and the impact that these differences have on the health of children is needed.

/2008/ Similar to previous year. //2008//

/2009/ There was a decrease in children living in TANF (grant) funding from 5.0% to 3.4% with some variation by race in 2007. Native Hawaiian or Other Pacific Islander (5.2%), white (4.9%) having higher estimates. 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//

Enrollment in Medicaid was found in 41,305 children 0-19 years of age, representing 12.8% of children in Hawaii. Of all the children in Medicaid, 20,169 of them were Native Hawaiian or Other Pacific Islander (16.6% of all Native Hawaiian or Other Pacific Islander). There were 10,797 Asian children were enrolled in Medicaid, (8.4% of the Asian child population). There were 7,165 Whites enrolled in Medicaid which corresponded to 16.9% of White children. There were no major

differences by ethnicity from the general child population in Medicaid enrollment. There were 38,102 children enrolled in Medicaid that were not Hispanic or Latino ethnicity (12.3% of the not Hispanic or Latino child population). Whereas, 1421 children were Hispanic or Latino children (13.4% of the Hispanic or Latino population) were enrolled in Medicaid. Native Hawaiian or Other Pacific Islander are over represented while Asians were under-represented. Since eligibility for Medicaid is partly determined by poverty status, programs that identify those at need are important including efforts by Hawaii Covering Kids.

/2008/ Enrollment in Medicaid was found in 44,268 children 0-19 years of age, representing and increase to 13.5% from 12.8% of children in Hawaii. //2008//

/2009/ Data was not updated since 2005 for Medicaid enrollment.//2009/

There were 13,213 enrolled in the SCHIP program, representing 4.1% of the child population between the ages of 0 and 19. Data for the SCHIP program were not available by individual race or ethnic groups in 2004.

/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/

The number of children aged 0 to 19 living in foster home care was 5,104 (1.6% of all children in Hawaii). Of all the children in foster home care, 2772 of them were Native Hawaiian or Other Pacific Islander (2.3% of all Native Hawaiian or Other Pacific Islander children), 574 Asian children in foster home care (0.4% of all Asian children), and 478 White children (1.1% of all white children). There were no major differences by ethnicity from the general child population that lived in foster home care. There were 4682 children living in foster home care that were not of Hispanic or Latino ethnicity (1.5% of this population), compared to 133 children who were Hispanic or Latino (1.3% of this population). Native Hawaiian or Other Pacific Islander are over-represented in foster home care. Further evaluation into the reasons why certain groups are over represented and the impact that these differences have on the health of children is needed.

/2008/ Similar to previous year. //2008//

/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/

Enrollment in food stamp programs was found in 43,435 children 0-19 years of age, representing 13.4% of children in Hawaii in 2004. There were 25,218 Native Hawaiian or Other Pacific Islander children enrolled in a food stamp program, reflecting 20.7% of this population. Whereas, only 3,576 Asian children were enrolled, reflecting 2.8% of Asian children. There were 8,140 White children enrolled in food stamp programs, which represents 19.2% of all white children. There were some differences by ethnicity in that 1,869 Hispanic or Latino children were enrolled in food stamp programs, reflecting 17.6% of this population. This compares to the 41,534 children who were not Hispanic or Latino ethnicity which reflected 13.4% of this population. Native Hawaiian or Other Pacific Islander, Whites, and Hispanic or Latinos are over-represented in food stamp programs, which may represent differences in poverty status. Further evaluation into the reasons why certain groups are over represented and the impact that these differences have on the health of children is needed.

/2008/ There were 37,703 children 0-19 years of age, enrolled in food stamp programs which represented 11.5% of children in Hawaii in 2006. This was a decrease from 13.4% in 2004. //2008//

/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/ethnic groups.//2009/

Enrollment in the WIC program was found in 38,729 children 0-19 years of age, reflecting 12.0% of children. Of all the children enrolled in WIC, 18.7% of them were Native Hawaiian or Other Pacific Islander compared to the 37.6% of the children population that this group accounts for. Whereas, 17.0% of those enrolled were Asian compared to the 39.8% of the child population in Hawaii. Whites account for 16.9% of the population and had a similar proportion (13.7%) enrolled in food stamp programs. A limitation is that, 40.7% of those involved in WIC reported more than one race and likely explains the low proportions of Native Hawaiians or Other Pacific Islanders enrolled in WIC. There were some major differences by ethnicity from the general child population by WIC enrollment. The majority of the children enrolled in Medicaid (76.5%) were not Hispanic or Latino ethnicity (96.0% of the child population), compared to 21.8% of the Hispanic or Latino children (3.3% of the child population). Further evaluation into the reasons why certain groups are over represented and the impact that these differences have on the health of children is needed.

/2008/ There were 41,985 (up from 38,729 in 2004) children 0-19 years of age, reflecting 12.8% of children (up from 12.0% in 2004). //2008//

/2009/ Enrollment in WIC continues with 42,380 in 2007 or 12.9% of all children aged 0-19.//2009/

The rate of arrests for juvenile crime was 3,961.8 per 100,000 children 0-19 years of age. Native Hawaiian or Other Pacific Islander (1634 per 100,000) had the highest rate of individual population race groups, followed by Asians (878.7 per 100,000) and Whites (858.1 per 100,000). The rate in those that were not Hispanic or Latino ethnicity was 3968.6 per 100,000, compared to a rate of 0.0 per 100,000 in the Hispanic or Latino children. Further evaluation into the reasons why certain groups are over represented and the impact that these differences have on the health of children is needed.

/2008/ Similar to previous year. //2008//

/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 with the highest rate still in the Native Hawaiian or Other Pacific Islander group.//2009/

Overall, 4.7% of children were high school dropouts and this varied by race with American Indian or Native Alaskan (11.4%) having the highest percentage, followed by Native Hawaiian or Other Pacific Islander (6.1%), White (5.4%), Black or African American (5.3%) and Asian (3.1%). 4.7% of children that were high school dropouts were not of Hispanic or Latino ethnicity, compared to 5.6% of those that were of Hispanic or Latino ethnicity. Further evaluation into the reasons why certain groups are over represented and the impact that these differences have on the health of children is needed.

/2008/ Similar to previous year. //2008//

/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, Native Hawaiian or Other Pacific Islander, and Black children. While 6.9% of those who reported Hispanic or Latino ethnicity compared to 5.1% without were high school dropouts.//2009/

HSI 10 GEOGRAPHIC LIVING AREA FOR ALL RESIDENT CHILDREN AGED 0 THROUGH 19 YEARS

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//

HSI 11 PERCENT OF THE STATE POPULATION AT VARIOUS LEVELS OF THE FEDERAL POVERTY LEVEL

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//

HSI 12 PERCENT OF THE STATE POPULATION AGED 0 THROUGH 19 YEARS AT VARIOUS LEVELS OF THE FEDERAL POVERTY LEVEL

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//

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 treatment 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//

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//

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//

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 through 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//

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. Contracts have been modified to include the additional TANF funds. A report on these improvements to the Healthy Start program is due to the 2009 Legislature. //2009//

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

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 2004

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//

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 2008)

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//

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.