

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: HI

APPLICATION YEAR: 2005

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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.

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; published June, 2003; expires May 31, 2006.

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. 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.

//2005/FHSD will work on a consumer friendly product from the Title V report for broad distribution that highlights the performance measure data. A link to the National Title V website may be placed on the newly redesigned Hawaii Department of Health website. //2005//

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

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 9am (Eastern Standard Time) in Washington, D.C. is 6 am in Los Angeles and 4 am in Hawaii.

The State is composed of seven populated islands located in four major counties: Hawaii, Maui, Oahu, and Kauai (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 73% of the adult population and 70% of children reside in the City and County of Honolulu on the island of Oahu, concentrated in the Honolulu metropolitan area. The neighbor island counties are Hawaii, Kauai (includes Niihau) and Maui (includes Molokai, Lanai, 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 Oahu. Consequently, neighbor island and rural Oahu residents often must travel to Honolulu for these services. Interisland passenger travel is entirely by air. Air flights are frequent, but comparatively expensive. 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 Kauai. This creates a financial barrier for neighbor island residents since round-trip airfare costs are about \$140.

//2005/ Due to rising fuel costs, Hawaii's two major inter-island airlines carriers have both cut back on flight schedules, implemented new pricing schedules, eliminated discount ticket coupons, and created more restrictions on ticket purchase. The cost of inter-island round trips may run as high as \$240. These measures have placed an extreme hardship on neighbor island travel.//2005//

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.

//2003/ According the 2000 Census, 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 Kauai County with a 13.5% increase to 58,610. Honolulu registered the least growth by county at 4.8% with 876,156 people. Current state projections anticipate the neighbor islands will continue to grow faster than Honolulu over the next 25 years.

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%).

//2005/ The population estimates have not changed dramatically since the 2000 Census. //2005//

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 there are of one or more race.

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 2001, approximately 7.0% of the state's public elementary school children were enrolled in the Students with Limited English Proficiency Program, an increase from 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 has experienced a sluggish economy for the past decade. The state had trouble emerging from the last recession, in 1990-91, and then was hard hit by the 1997-98 Asian currency crisis, which cut into the state's primary industry: tourism. While there are tentative signs of recovery with increased tax revenue and lower unemployment, Hawaii continues to rank 50th in economic growth in the nation.

In a recent report by the U.S. Bureau of Economic Analysis, Hawaii showed the slowest growth in real gross state product in the U.S. for the period of 1992-99. Hawaii was the only state with a negative GSP (-.3% compared to the average U.S. GSP of 4%). Unemployment for Hawaii was 4.7% in April 2001 compared to the national rate of 4.2%. The National Governor's Association reported in 1999 that Hawaii and Alaska were the only states to cut their state budgets. This poor economic environment significantly impacts families since Hawaii's cost of living is 30-40% higher than that of the rest of the nation.

Another indication of poor economic conditions is the growing numbers of children enrolled in Hawaii's public schools' free lunch program. In 1999, 49% of the public elementary students and 37% of the intermediate and high school students received free or reduced-price lunches. The number of students receiving lunch subsidies has increased by over 59% since 1990. Anecdotal reports from the Hawaii Food Bank and other philanthropic organizations indicate an increase in requests for emergency assistance from low-income families.

Poor economic conditions are exacerbated on the rural neighbor islands. For instance, Hawaii County has the lowest per capita income, the highest unemployment rate, and the highest number of children living in poverty in the State. These glaring statistics contribute to issues of substance abuse, family violence, child abuse, unintended pregnancies, and other perinatal issues and substantial health disparities.

/2003/ Hawaii is now in a recession, thanks to the combination of a generally slow economy throughout 2001 and a devastating drop in visitor arrivals and revenues after the attacks on September 11th. By October of 2001 there were massive layoffs in the hotel and visitor industries. Twenty six thousand workers in tourist related fields had filed for unemployment benefits. Combined with 600,000 fewer visitors coming into the state, this contributed to a \$315 million state budget deficit. In July 2002, tax revenues plummeted another \$88 million more than projected, prompting the Governor to consider further cuts in the state budget this year.

Most forecasters are expecting the state's economic recovery to be much less precipitous than its decline, partly because the steep reductions in several key areas were not only caused by the September 11 disaster, but also by previous weakness in the global economy.

Military spending comprises a considerable "slice" of Hawaii's economic engine. Military personnel spending has not dropped off as much as it did during the Gulf War. However large deployments of military force from Hawaii could change that. In addition, the possible transfer of the Pacific command to the continental U.S. has some government officials concerned.

/2004/ Hawaii's economy has continued to worsen this past year as a result of military action in Iraq and the SARS (Severe Acute Respiratory Syndrome) outbreak in China. During uncertain times individuals restrict their travel plans, thus severely impacting Hawaii's tourism industry. The State projects a \$152 million dollar shortfall for fiscal year 2004. The reduction in tax revenues has also been exacerbated by a series of tax credits given to various industries to stimulate economic growth. The Council of Revenues estimates the cost of Act 221, which provided tax credits to the film and other high tech industries, to be \$48.4 million by the end of June. In total, it is expected that a dozen different tax credits for business and individuals will result in a loss of \$180 million. General excise tax collection was down by 5.1%, corporate income tax was down by 36.9%, and individual income tax revenues were 56.3% lower this year than April 2002. Despite declining revenues and projected layoffs, Hawaii's unemployment rate is half of the national rate, 3.4; this may be a reflection of increasing number of individuals who have less than full time employment. //2004//

/2005/ After more than twelve years of economic down turn Hawaii's economy seems to be on an upward swing. While the current administration is cautiously optimistic there are several strong indications that Hawaii is experiencing a time of economic recovery. Hawaii's jobless rate fell to 3% in June, the lowest in the nation.

Hawaii's lower unemployment rate is clearly influenced by the tourist and service economy which often calls for a higher rate of casual or part time employment. However, there are other market factors indicating a strong recovery. Tax revenues for the state have increased by 8% this year; this is above the 5.2% projected growth forecast last year. The visitor count shows a 14% increase over the previous year, and the cruise industry market seems to be rapidly taken hold in Hawaii.

Home prices have increased by 20% from the previous year. The median single family sales price is \$445,000, up by \$10,000. The real estate market is very active partly because of a slowdown in home construction due to a cement truck drivers strike on Oahu for nearly 2 months. The average length of time from posting to accepting an offer has been no more than 19-20 days. This has created a housing shortage especially for the lower economic groups and there are reports of an increase in homelessness. //2005//

POLITICAL CONTEXT

Two major themes occupied the 2001 legislative session: Government Reform and the Felix v. Cayetano Consent Decree relating to mental health services for children and adolescents. The legislature was successful in reducing benefits to state employees under the guise of making government more efficient. A major disruptive element this year was a seven-week statewide teachers strike and a five-week statewide strike of the University system. Litigation to improve the state mental health system, both children/adolescent and adult, and the developmental disabilities program continues to drive the Department of Health's budget. While cornerstone Title V and preventive health programs have lost substantial state funding, this has been offset by the infusion of Tobacco Settlement funds and aggressively seeking federal funding streams.

/2004/ Hawaii elected a new Governor in November 2002. Governor Linda Lingle became the first female Governor of the State, and the first Republican in four decades. Management and priorities are therefore shifting with the replacement of all government department directors with new political appointments. The major theme of the 2004 legislative session has been balancing the budget with

declining revenues. The Governor is expected to veto fifty bills passed this legislative session because of their fiscal impact. Unfortunately, some of the restrictions have a direct impact on health care services for the uninsured and other vulnerable populations. In order to balance the budget, Tobacco Settlement Funds have been used to supplant general fund appropriations to various prevention programs. An example is the replacement of \$5.3M of the Healthy Start general funds with Tobacco Settlement Funds. The Tobacco Settlement Funds was exempted in the past from the central service and administrative fees, approximately 6.5%, resulting in a \$615,000 reduction to the Department of Health share of the funds. The Department will assess which of the current initiatives will be reduced or eliminated. //2004//

/2005/ Three topics dominated the legislative session this year: substance abuse, educational reform, and finances. The Governor's Administration championed the issue of the rising rates of substance abuse, specifically crystal methamphetamine, in response to a groundswell of concern from law enforcement, service providers, and local communities. Hawaii reports the highest rates of crystal meth use in the U.S. among male arrestees.

The Lieutenant Governor's Office organized statewide community meetings on the issue that culminated in a State Drug Summit and the development of a State Drug Control Plan. Of particular concern to communities were the effects of the highly addictive drug on domestic violence, the breakdown of families and the increase of crimes, particularly violent crimes. Legislative leaders convened their own Joint Committee to investigate the issue and develop a legislative package.

A primary focus of Governor Lingle's agenda is educational reform calling for the dismantling of a centralized Board of Education to a County based system. Opposed by the State Superintendent of Schools and the Democratic-controlled Legislature, an alternative school reform bill was proposed by legislative leaders.

Although the economy is rebounding, the current administration is calling for fiscally prudent spending. This legislative session was quite contentious with the Governor vetoing the state budget bill, only to have it overridden by the state legislature. It is uncertain whether state government will experience budget restrictions in fiscal year 2006. There is concern that approved collective bargained salary increases for government employees will result in a budget shortfall. //2005//

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 Hawai'i 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.

In 1999 the Legislature passed Act 91 based on the recommendations by the DOH and DOE which shifted the responsibility for service delivery from a primarily off-campus, medically-based service delivery system under the DOH to a primarily school-based service system under DOE. The development of the service system in response to the Consent Decree has resulted in an extraordinary increase in the number of children identified as Felix class (an estimated 2,894 children in 1994 to 11,842 children in 2000) and expenditures to acquire services for these children. The high costs have raised considerable concern by the public, parents of regular education students, and the Legislature. Accountability for the Felix funds by the DOE and DOH has been incomplete generating highly critical audits and a recent Legislative Investigation raising serious questions about unclear requirements for compliance, lack of administrative oversight leading to fiscal mismanagement, conflicts of interest in contracting services, profiteering, and wasteful spending. Concerns have also been raised about inefficient delivery of services and misidentification of Felix class children.

Felix Programs in FHSD, CSHNB Early Intervention Section (EIS) and MCHB Healthy Start, 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.

Another important legislative initiative affecting children, was the appropriation to develop a Pre-Plus program, the state's first attempt at addressing universal pre-school. The Good Beginnings Alliance, a private public partnership working to increase availability and quality of early childhood education and care, successfully lobbied for the funding. The Alliance partners with the State and with private organizations to leverage resources to subsidize childcare services.

/2005/ The Pre-Plus program has struggled with administrative changes, construction delays, but has now opened 7 early education program sites at existing public elementary schools in 2003. Four more sites are scheduled for opening this year. The Department of Human Services administers the program and has construction funds to build 8 additional facilities. Construction on six sites is underway and another 2 sites are being contemplated. //2005//

/2003/ State lawmakers return to session this year to balance the budget and boost the state economy in the wake of the September 11 terrorist attacks. Continued revenue shortfalls for the state will most likely result in cuts to state programs in health, education, and social services. This could lead to a decrease in resources for maternal and child health services. Legislative oversight of Felix Consent Decree expenditures continued with the Legislature issuing a report of their findings.

/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 is sustainable.//2004//

//2005/ A major accomplishment for the State of Hawaii was the favorable finding by the court ruling that Department of Health and Department of Education has demonstrated substantial improvement in the educational and mental health services for special education children. While quarterly reporting is still required it is more a matter of formality rather than court oversight. The Departments of Education and Health have been given the authority to self monitor the system. //2005//

The noteworthy health bills that passed in the 2002 legislative session include:

Health insurance (HB 1761 HD1 SD2 CD1)

Prohibits health insurance rates that are excessive, inadequate or unfairly discriminatory. Requires health insurers to submit rate filings for approval by the insurance commissioner, and to disclose the methods they use to set those rates. Requires health insurers to seek state approval before raising healthcare premiums.

Prescription drugs (HB 2834 SD2 CD1)

Establishes the Hawaii Rx Program to make prescription drugs more affordable to Hawai'i residents. Under the program, the state would negotiate discounts on medicine with pharmaceutical companies on behalf of people in a purchasing pool. People in the pool would be able to buy the discounted medicine at pharmacies. The program is scheduled to begin January 2005.

Medicaid prescription drug expansion (HB 1950 SD2 CD1)

Establishes the Medicaid prescription drug expansion program to offer discounted prescription drugs to qualified patients whose income is at or below 300 per cent of the federal poverty level.

Genetic testing (SB 2180 SD2 HD1)

Prohibits discrimination by employers based on a person's genetic information, and prohibits health insurers from denying or limiting health coverage based on genetic testing.

Birth Defects Surveillance System (SB 2763 SD2 HD2 CD1)

Increases marriage license fees from \$50 to \$60, of which \$10 will be allocated to support the Hawaii Birth Defects Surveillance Program.

Tobacco Settlement Funds

Half the monies earmarked for tobacco prevention programs were diverted to fund construction for the new University of Hawaii Medical school. About 25 % of the Tobacco Settlement money, \$10 million, was going into a Tobacco Trust Fund each year, with earnings being used for prevention programs. The Legislature cut that to 12.5 %, reducing the trust amount to \$5 million.

//2004/ Legislation of interest to the Title V population included:

House Bill 123 Relating to the Practice of Pharmacy

This allows the dispensing of emergency contraceptive pills by pharmacists in collaboration with a licensed physician. Pharmacies will now be a new access point for contraception referrals and education. Another bill requiring hospitals to offer emergency contraceptives to rape victims was vetoed by the Governor because of objections raised by religious based hospitals.

Senate Bill 1305 Relating to State Funds

This appropriates to the Department of Health \$1,300,000 to provide resources to nonprofit, community-based health care providers to care for the uninsured. This bill also included basic subsidies to several community health centers were reduced by 15%.

Senate Bill 1423 Relating a Commission on Fatherhood

This establishes the Commission on Fatherhood within the Office of the Lieutenant Governor, to promote healthy family relationships between parents and children.

Tobacco Settlement Funds earmarked for the Department chronic disease prevention activities was reduced by more than \$6 million to offset general funds for core programs and to budget and finance. //2004//

/2005/The Reinvesting Education Act changes the educational budget process to provide school principals with greater autonomy to manage their school budgets. However, the reform fell short of the Governor's hope for complete reform and the creation of seven rather than on Board of Education.

The Winning Against Ice package increased penalties for drug dealers, appropriated nearly \$15 million in new financing for drug treatment and prevention services, it also required health insurance plans to cover substance abuse treatment services.

The Hawaii RX Plus Act allows individuals with incomes to 350% of the poverty level to purchase prescription drugs at discounted rates.

Act 221 which provides for tax credits for high-tech business was extended for another five years, however the eligibility and enforcement of this measure was tightened to avoid the abuse which was reported earlier resulting in a serious reduction a tax revenues without the creation of sustainable employment.

The legislature again used the vehicle of the Rainy Day Fund to provide increased funding for community health centers, oral health, and community based social services program. The Governor has challenged the wisdom of this type of spending, and it is therefore uncertain at this time whether all of the funds appropriated will be released and expended. //2005//

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 is 11,008 cases. Of the current number, approximately 6,000 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 3,000 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 2,000 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 5,000 cases per month and a unduplicated number of 10,000 per year.

/2003/ 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, approximately 1,200 families lost eligibility due to the five year time limit. A disproportionate number of these families live on the island of Hawaii.

/2005/ Currently, TANF enrollment is 9,007 cases. Of the current number, approximately 4,380 clients are expected to be able to enter the work force. There are 2,140 TANF recipients who are currently employed and have been able to earn back the 20% reduction in their cash benefits. An additional 2,200 recipients are obtaining job experience with volunteer

placements. The First-to-Work Program is servicing 3,491 cases per month, an unduplicated number of 12,598 per year. Since 2002 an additional 2000 families have exhausted benefits. //2005//

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. The increase will be phased in over a two year period and would place Hawaii fifth in the nation for highest minimum wage.

HEALTH INSURANCE

According to provisional data from the 2002 Hawaii Health Survey conducted by the DOH Office of Health Status Monitoring, 4.7% of the state's population is uninsured. Hawaii historically has had a large proportion of its population covered by some form of health insurance, a legacy from traditional Hawaiian society, the subsequent plantation era, and the rise of strong labor unions.

This 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 and includes a minimum set of mandated benefits. 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, coupled with Hawaii's poor economy have raised concerns about the Act and its impact on small businesses in Hawaii.

To address rising health care costs, the Hawaii health insurance market has shifted toward managed care in both the private and public sectors. In 2000, 85% of insured Hawaii residents were covered under some form of managed care program, an increase of 49% since 1992.

The financing of health care in Hawaii's private sector is dominated by two health plans: the Hawaii Medical Service Association (HMSA, an Independent Licensee of the Blue Cross and Blue Shield Association) which was founded in 1935, and Kaiser which began operating in Hawaii in 1958. 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.

In 2000, government funded insurance represented 33% of residents in Hawaii: 13% Medicare, 10% Medicaid, and 3% TRICARE which provides health care to military families and retirees.

The Hawaii QUEST demonstration project is a Medicaid 1115 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. The original 1115 waiver was approved for a five year period and must subsequently be extended every three years thereafter. QUEST has two 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 are used to expand coverage.

The initial QUEST eligibility criteria allowed individuals with incomes up to 300% of the Federal Poverty Level to be enrolled into managed care and also covered individuals that were previously not eligible for Medicaid, including individuals covered under the State Health Insurance Program (SHIP). The goal to expand coverage was successful and in January 1996, over 160,000 individuals were enrolled in QUEST.

In 1996, due to a lawsuit and budget constraints, several changes were made in the eligibility criteria for QUEST: 1) the income test was dropped to 100% of the FPL for most individuals; 2) a cap of 125,000 individuals was placed on the program; and 3) adult preventive dental services were dropped from coverage. Certain groups of individuals are not subject to the cap and can be enrolled in QUEST at any time, including: pregnant women, children under 19 years of age, foster children, and children in subsidized adoptions under the age of 21. Exception to the 100% FPL limitation include pregnant women and infants under one year of age whose countable family income does not exceed 185% of FPL and children age 1 but under age 6 whose countable family income does not exceed 133% of FPL. There are no asset tests for individuals under the age of 21.

In 2000 the Hawaii Medicaid program was expanded to include the State Children's Health Insurance Program (SCHIP). This allowed coverage for children under the age of 19 whose countable family income does not exceed 200% of FPL. Additionally, coverage is available to 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.

Effective November 1, 2001 the State implemented section 1931 of the Social Security Act. Section 1931 provides Medicaid coverage to persons who meet the AFDC eligibility requirements, as they existed on July 16, 1996 in the AFDC State Plan. The provisions of section 1931 apply to persons who are receiving cash assistance payments as well as those who do not. With implementation, certain TANF recipients will not be eligible for QUEST. The income and categorical requirements are slightly different from the QUEST program. Concurrently, the State implemented section 1925 of the Act. The provisions of section 1925 provide Transitional Medical Assistance to certain families who lose section 1931 eligibility.

With these many changes in the eligibility requirements, the enrollment in the QUEST program declined after the 1996 enrollment restrictions, was stable for a period of time and has been rising over the past few years due to economic changes in Hawaii. Comparing the numbers at the end of the last few years we can see this increase: December 2001 -- 129,520; December 2002 -- 137,743; December 2003 -- 144,801

//2004/ The 2002 the enrollment cap was exceeded. QUEST enrollments now total 133,229 including those groups that are exempt from the cap. //2004//

//2005/ QUEST enrollment is currently at 150,336 in May 2004, nearing the high previously seen in 1996.//2005//

The QUEST program provides all medical care through contracted managed care plans. Recently, all dental services switched to a fee-for-service Medicaid program. Currently, individuals eligible for enrollment in QUEST can choose from three participating managed care plans: AlohaCare, HMSA and Kaiser. Not all plans are available on all islands.

The initial program design of the QUEST demonstration project envisioned three phases: Phase 1 to enroll most of the Medicaid population into managed care; Phase 2 to enroll the Aged, Blind and Disabled (ABD) population in managed care; and Phase 3 to enroll the Long Term Care (LTC) population into managed care. Although the State has moved forward on several occasions to begin enrolling the ABD population into managed care, due to budget neutrality concerns, this population remains in fee-for-service.

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. HMSA Foundation has submitted an application for a Robert Wood Johnson Foundation grant to develop strategies to assure universal insurance coverage. RWJ is interested in Hawaii as a model to address the uninsured.

/2004/ In January 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 will present its data and proposed options to key policy makers in a fall conference. //2004//

/2005/ The Hawaii Uninsured Project has been partially successful in its efforts to increase the number of insured in the state. A document entitled On Common Ground was published and distributed to policy makers which outline key strategies for the improved coverage. Partially as a result of this broad based stakeholder effort, additional funds were appropriated to the community health centers, federal dollars were received to address the health expenditure demands of the Compact Free Associated States population, the Medicaid cap for adults was increased by 1,000 individuals, and coverage for pregnant immigrant women was approved. The impact of the Prepaid Health Care Act was explored and the project is in the formative stages of creating an insurance plan that is affordable for the part-time and self-employed. //2005//

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 2001 - 7,223 children were enrolled in SCHIP.

/2004/ As of December 2002 - 9,056 children were enrolled in SCHIP. //2004//

/2005/ As of December 2003 - 10,924 children were enrolled in SCHIP. As of May 2004 - 12,136 children are enrolled. In January 2004 the Department of Human Services introduced a shortened and simplified application process and has allowed for passive re-eligibility. The Department continues to work closely with Hawaii's Covering Kids, Robert Wood Johnston initiative to increase outreach and enrollment in the SCHIP program. //2005//

Effective July 1, 2000, legal immigrants, refugees, and those born in the Marshall Islands, Federated States of Micronesia and Palau were eligible for QUEST under a state-funded immigrant children's program which has the same eligibility requirements as SCHIP. As of December 2001 - 2,175 immigrant children had been enrolled.

/2004/ As of December 2002 - 1,915 immigrant children had been enrolled. //2004//

/2005/ As of December 2003 - 2,229 immigrant children had been enrolled. //2005//

STATE DEPARTMENT OF HEALTH: CURRENT PRIORITIES & INITIATIVES

Within Hawaii's changing health care environment the State Department of Health is focusing on several initiatives and current priorities.

HEALTHY HAWAII INITIATIVE

The 2000 Legislature authorized the Department of Health's Healthy Hawaii Initiative (HHI). This

Initiative is a major, statewide effort to encourage healthy lifestyles and environments with emphasis on children and adolescents in relation to 3 critical areas: poor nutrition, lack of physical activity, and tobacco use that contribute significantly to the development of chronic disease. HHI is supported by a portion of the Tobacco Settlement Funds awarded to the state through a class action suit brought against the tobacco industry.

HHI will support a mixture of public and professional education, community and school based programs. The focus is on infrastructure development to support sustainable health resources for the state. Efforts include: 1) funding 10 new resource teachers to help implement new health and physical education standards in the public schools, 2) expanding data collection on youth regarding tobacco use and to generate community level health information through the Youth Behavioral Risk Survey, 3) create a health data Institute at the University of Hawaii to expand assessment and epidemiological public health capacity, and 4) funding community-based opportunities to promote healthy lifestyles.

//2005/ HHI and the State of Hawaii have received national recognition for this state-directed prevention program from the Centers for Disease Control, the U.S. Department of Health and Human Services and the California Center for Health Improvement. //2005//

HAWAII OUTCOMES INSTITUTE

The Hawaii Outcomes Institute has been established in the Department of Epidemiology and Biostatistics of the John A. Burns School of Medicine at the University of Hawaii. The Institute is funded from the Tobacco Settlement Funds and its mission is to identify community needs and priorities, support research on best practices and strategies, and assist individuals and communities in evaluating health outcomes. It is expected that the Institute will, in addition to other technical support activities, collaborate with the Department of Health in evaluating the success of the Healthy Hawaii Initiative and help rebuild the University School of Public Health.

//2004/ Hawaii Outcomes Institute has published Community Profiles for each of the counties and has this information website accessible. Training of department staff on data use has also begun this year. //2004//

SCHOOL HEALTH

The Healthy Hawaii Initiative has funded the Coordinated School Health Program, a joint undertaking of the Departments of Education and Health. It is based on the Centers for Disease Control and Prevention model that supports the reduction of chronic disease risk factors as well as other behavioral risks. The program uses a national framework that systematically addresses these risk behaviors through eight components. Sixteen pilot sites/school complexes have been selected to implement the program and progress to date is currently being evaluated. The Healthy Hawaii Initiative also supports the implementation of standards-based Health Education and Physical Education (HE & PE) with funding to the DOE for one state-level Educational Specialist, two state-level Resource Teachers and eight district-level Resource Teachers. These personnel provide the catalyst necessary to implement quality, standards-based HE & PE in a system dominated by reading, social studies, science and math.

HEALTH INFORMATICS

The Health Information Coordination Special Project was created to contribute to the improvement of public health performance and is designed to make information technology and tools serve the needs of public health practice. A major activity of the project will be to develop a data warehouse that consists of information gathered from inside and outside the department that will be integrated into a format that facilitates public health analysis. It is also funded through the Healthy Hawaii Initiative.

INTEGRATED CHRONIC DISEASE PLAN

The Department of Health has initiated the development of an Integrated Chronic Disease Plan for the State of Hawaii. The plan is being created with an emphasis on program activity and integration and a focus on the reducing tobacco use, improving nutrition, and supporting physical activity and exercise.

//2005/ The Director of Health and Deputies have led the Department in a year long strategic planning process. This has result in the establishment of a new vision for the department: "Healthy People, Healthy Communities, Healthy Islands". Six goals have been established for the department. Of note is the 6th goal "Attain a culture of organizational excellence that provides effective public health programs and leadership for the State of Hawaii." In addition, the Department has clearly prioritized the issues of health equity and chronic disease prevention. //2005//

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 2000 Session of the Hawaii State Legislature provided level funding for most maternal and child health programs. Notable exceptions were an emergency appropriation of \$7.5 million to assure the full implementation of Healthy Start and other mandated early intervention services under IDEA Part C to infants and children up to three years of age. Fiscal year 2002 is expected to see a \$15 million increase for these programs. FHSD has worked to maximize federal cost share for EPSDT-related services to Medicaid eligible children. Since September 1997, the State of Hawaii has received \$4 million in federal reimbursements under the Medicaid Early Intervention Carve Out. This resource has been a critical support in light of increasing needs.

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 will be used to fund an 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 Middle School Youth Behavior Risk Survey, and other health surveillance tools; maximizing use of a CDC-Title V funded MCH epidemiologist; obtaining additional training and skill development through participation in the CityMatCH Data Use Institute and Periods of Risk Analysis with the National Working Group on Urban Maternal and Child Health Assessment.

The Division has contracted with a private firm to develop its Early Intervention Data Management System. Data linkage initiatives between newborn screening programs and vital statistics are currently underway as well as the development of a statewide integrated perinatal data system.

WIC's new statewide automated data processing and client tracking system will provide important program data for this large at-risk population and facilitate linkage with vital statistics, Medicaid, and other datasets. The data will help strengthen collaboration between the WIC program and other MCH programs in childhood immunizations, breastfeeding, oral health, and assuring health insurance coverage for low income children and mothers. /2003/ Work on the WIC data processing and client tracking system is largely completed and is providing client tracking data for program use.

/2004/ WIC's statewide automated information system was modified with \$249, 373 in earmarked USDA funds in late 2002 to implement magnetic imaging character recognition (MICR) printers for program integrity purposes and to incorporate changes in the nutrition risk factors and race/ethnicity/ancestral origin data collection. //2004//

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.

/2005/ 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 three staff have graduated from the University of Hawaii Maternal and Child Health Certificate program, another four staff are currently enrolled in the program.

The Maternal and Child Health Branch Chief was named as the Department's Program Manager of the Year, and WIC Program Supervisor was named the Employee of the Year for the Department as well. //2005//

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.

CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH (CSHNB)

The Children with Special Health Needs Branch, consisting of 143 full time employees (19 are Title V funded), promotes integrated systems of care that assure the population of children with special health care needs and their families receive appropriate services to optimize their quality of life. The branch includes the following programs: Early Intervention Services, Preschool Development Screening, Newborn Hearing and Metabolic Screening, the Children with Special Health Needs Program, Nutrition Services, Genetics Program, and Birth Defects Program. While CSHNB will continue to provide direct and enabling services, the branch is increasingly building its infrastructure capacity.

MATERNAL AND CHILD HEALTH BRANCH (MCHB)

The Maternal and Child Health Branch, comprised of 80.0 FTEs (17 are Title V funded including several neighbor island positions), works to promote and protect the health and well-being of mothers, infants, children and their families in the context of their communities. 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.

//2005/ In 2004 a branch reorganization plan was completed. MCHB is now divided into three program sections: Women's Health, Children and Youth Wellness, and Family and Community Support. //2005//

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 federal FY 2001, WIC served an average of 32,455 individuals a month, drawing closer its goal of providing nutritional services to an estimated 41,000 eligible persons statewide. Approximately 50% of the caseload are children age 1-5 years, 25% are women and 25% are infants. With 117.5 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 and two hospitals 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."

//2004/ In FFY2002, Hawaii WIC served an average of 32,986 individuals a month, a slight increase from the previous year. WIC's contract with the Queen's Medical Center was terminated at their request with provision of services ending in December 2001 with participants transitioned to other agencies. The 117.5 FTEs include State Agency staff and staff at the eight state-run local agencies, but does not include 3.0 FTE information systems State Agency staff organizationally attached to DOH HISO nor 0.5 FTE project coordinator funded by Association of Teachers of Preventive Medicine

(ATPM). //2004//

/2005/ In FFY2003, Hawaii WIC served an average of 32,788 individuals a month.//2005//

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 Kauai, Maui and Hawaii and follow political county jurisdictions. Kauai DHO is also responsible for the island of Ni'ihau. Maui DHO is responsible for the islands of Lanai and Molokai. 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.

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 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 Oahu. On Oahu, 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 Coordinator functions on the island of Hawaii are handled by the Nurse Manager for Special Services. Among her many DHO responsibilities, Karleen Yoshioka provides administrative supervision for Title V programs including Children With Special Health Needs Program (2 social workers and 1 half time clerk), the Early Intervention Section state and private contractor programs (7 social workers, 1 OT program manager, 1 OT, 1 PT, 1 special education teacher, 1 half time speech pathologist, 2 paramedical assistants, 1 data clerk, part-time clerk typist), 1 clerk steno and oversight for the Federal Healthy Start Initiative grant, Eliminating Disparities in Perinatal Health, "Malama A Ho'opili Pono" project. The supervision of the perinatal support services and the WIC program is handled by individual program supervisors.

Other related MCH functions include facilitating the Hawaii Dental Task Force meetings and representing the DHO in the Childhood Lead Poisoning Prevention coalition meetings on Oahu. Additional DHO responsibilities include the administrative oversight for the Breast and Cervical Cancer Control Programs and Start Living Healthy Coalitions, representing the DHO at the Hawaii Poison Center Community Advisory Committee (Oahu), the East Hawaii Friends For Foster Families and the East Hawaii Regional Planning Committee.

/2004/ Karleen Yoshioka is now head of the Hawaii island District Health Office. She is currently overseeing the duties of FHSD Coordinator position which is currently vacant. //2004//

/2005/ Maylyn Tallett was hired in April 2004 as the FHSD Coordinator for the Hawaii island District Health Office. The following duties for the FHSD Coordinator have changed: the oversight of Malama A Ho'opili Pono project is handled by another program supervisor and additional staff for the Early Intervention Section now includes 1 Human Service Professional Supervisor and a full time Speech Pathologist. Other DHO responsibilities include the facilitation and coordination of the Department of Education - Special Education and Department of Health - Early Intervention meetings to address EI transition issues. The Coordinator is also involved with the Start Living Healthy Tobacco Coalition, the Big Island Keiki Injury Prevention Coalition and participates with the Hawaii District Bloodborne

MAUI COUNTY

The FHSD programs in Maui County are supervised by a registered nurse, Sandy Dioso, who is responsible for the administrative supervision of all FHSD programs and employees, which includes WIC (2 nutritionists, 7 paramedical assistants, 2 clerks, 1 clerk-typist), Early Intervention (4 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 for children eligible for IDEA services. Additional duties include special projects related to Title V, FHSD, and/or the Maui District Health Office like the current support provided for a community planning process for the rural community of Hana to identify health and service needs for youth.

/2003/ The FHSD Coordinator position for the county of Maui is currently vacant since Sandy Dioso left the position in Spring 2002. Polly Busby, MCH registered nurse, is temporarily acting coordinator. The position will be filled permanently by a registered nurse who will be responsible for the administrative supervision of all FHSD programs and employees. 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 see how effective these Title V programs are. He/she will also identify unmet needs of the Title V target population and, through partnerships with other agencies, design special programs to address these issues. Currently, examples of such special programs for Maui include, fitness, oral health, nutrition, substance abuse, and food contamination with mercury.

/2004/ Jeny R. Bissell was hired November 2002 as the FHSD Coordinator/FHSS Supervisor of the Maui District Health Office. Polly Busby, R.N. returned to her position as the MCH Coordinator for Maui. Other duties for the FHSD Coordinator include participation in the Maui State Agencies Servicing Children, Start Living Healthy as the Maui DHO Nutrition/Physical Activity Liaison, Tobacco Coalition as the Alternate Maui DHO Liaison, Title IV B Regional Planning Group, Primary Care Roundtable, and County level health and human service coalitions that include Aire Fresco (tobacco cessation) and Enlace Hispano (assure outreach to the Spanish speaking community). //2004//

KAUAI COUNTY

The Kauai FHSD program manager, Dely Sasaki, has clinical nursing experience, and provides the administrative supervision and support to the Title V programs which include 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, MOMS (Malama ?Ohana Mother's Support), 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 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, Get Fit Kauai Coalition (promoting physical activities and good nutrition), and the Kauai Keiki Injury Prevention Coalition.

/2005/ Duties of the FHSD Coordinator have changed somewhat. The MOMS project has been completed. Additional duties include: chairing the Integration Committee of the Mayor's Drug Task Force (formerly known as the Kauai Drug Task Force); Kauai liaison to the Hawaii Islands Oral Health Task Force, Kauai Planning And Action Alliance, the Hawaii Comprehensive Cancer Control Coalition; serves on the Advisory board of the Hawaii Poison Center and the Kauai Breast and Cervical Cancer Control program; provides leadership on Kauai with the Asian American Network for Cancer Awareness Research and Training (AANCART) with focus

on the Kauai Filipino population; and board member for the KPAA which is a community coalition to address Kauai's economic development, environment, health and culture, public education, and solid waste reduction. //2005//

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. Over 100 purchase of service contracts, memorandum of agreements and fee for service contracts were executed in state fiscal year 2001 totaling nearly \$29 million to deliver direct and enabling services to the MCH population. All vendors with FHSD contracts must report on uniform performance measures that assure the quality of care. Contracts are monitored by FHSD program staff by area of expertise.

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.

//2003/ Several administrative position changes have occurred over the past year. Deputy Director of Health Anthony Ching resigned. Family Health Services Division Chief Loretta Fuddy was appointed to temporarily fill the position until December 2002. Dr. Stephen G. Karel became the Interim Chief of the Family Health Services Division in January 2002 during Ms. Fuddy's absence. HRA Deputy Director, Dr. Virginia Pressler resigned in May 2002. Each month HRA Division Chiefs will rotate into the position. This fall a new Governor will be elected (the current Governor is not allowed to run for re-election due to term limits) and DOH administrative appointments may change at the end of this year. *//2003//*

//2004/ The election of Governor Lingle has resulted in the appointed 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; Jane Kadamuro, DrPH is the Administrative Deputy, and Larry Lau is the Environmental Health Deputy. Loretta Fuddy, who served as the Administrative Deputy under the previous administration has returned as Family Health Services Division Chief. *//2004//*

D. OTHER MCH CAPACITY

There are approximately 388 full-time equivalent employees in FHSD. This includes temporary and permanent positions. Of the total, roughly 40 FTEs are funded using federal Title V monies. Most of the Title V funded positions have been created to build the Division/Branch level infrastructure capacity. Approximately 94 FTEs of the Division employees are based in the three district health offices on the neighbor islands: 57 FTE on Hawaii island, 13 on Kauai and 24 on Maui. The Division has 2 epidemiologists located at the Division level and at MCHB (plans are underway to establish another epidemiologist position at the Division level); 6 research statisticians at Division level and at the MCH and CSHN branches; 6 planners at Division and MCHB; and 10 data processing staff at Division level and at WIC and CSHNB.

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. The only 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.

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 the past two 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 been instrumental in the establishment of such preventive maternal and child health programs as Healthy Start (child abuse and neglect prevention), BabySAFE (Substance Abuse Free Environment), Council on Chemical Dependency and Pregnancy, and the Perinatal Support Services Program. 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.

//2003/ In August 2001 Ms. Fuddy was appointed the Deputy Director for Health for the Department of Health until December 2002. Stephen G. Karel became the Interim Chief of the Family Health Services Division in January 2002 during Ms. Fuddy's absence. Dr. Karel received his MPH in health services administration from the University of Hawaii. He also received his DrPH from the University of Hawaii in health planning and evaluation. Prior to joining the Department of Health, Dr. Karel spent more than 10 years as the senior program planner and country manager for the World Health Organization in Laos and Papua New Guinea. He also has served as the Executive Director of the Pacific Island Health Officers Association and was extensively involved in strategic planning and policy development for the six member countries and jurisdictions. Dr. Karel has spent more than 21 years in health policy, planning, and evaluation in the Asia and Pacific Region. Ms. Fuddy is expected to return as Division Chief for FHSD in December 2002.

//2004/ Ms. Fuddy returned to the position of FHSD Division Chief in December 2002. //2004//

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 six years. She graduated from the University of Hawaii (UH) with a degree in Biology and received her M.D. from University of California San Francisco, in 1976. She pursued residency at Kapi?olani 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 Branch and School Health Services Branch, and the 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 35 years of experience in maternal and child health and public health nursing. She has served as Maternal and Child Health Branch Chief for two years 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 Wai?anae, Oahu overseeing school based health and employment services to adolescents.

FAY N. NAKAMOTO, WIC SERVICES BRANCH CHIEF

Fay N. Nakamoto RN, BSN, MPH has served as WIC Director and Chief, WIC Services Branch since 1995. Her prior experience with the Department of Health includes Assistant to the Director of Health, Public Health Administrative Officer, Comprehensive Health Planning Officer, Program Budget Analyst, Family Planning Project Director, and Public Health Nurse. She has participated in research with the University of Hawaii, School of Public Health as Junior Researcher on four genetics studies. In 1999 Ms. Nakamoto received the National Governor's Association's award for distinguished service to State Government, the first recipient in state to receive such a distinction.

/2003/ In January 2002 Ms. Nakamoto retired. The new WIC Services Branch Chief is Linda Chock, MPH, RD. She previously served as the WIC Clinic Operations Section Chief since 1997. Her 23 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. //2003//

CHARLENE GASPAR, NURSE CONSULTANT

Ms Gaspar, RN, MPH has over 30 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 Oahu 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 ten 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.

DR. LINDA ROSEN, MEDICAL DIRECTOR

Dr. Rosen is currently Medical Director for the Family Health Services Division and Pediatric Medical Director for Emergency Medical Services, State of Hawaii, Department of Health. She graduated from UCLA with a degree in Biology and received her M.D. from Baylor College of Medicine in Houston, Texas, in 1979. She pursued residency and fellowship training in Pediatric Critical Care in Houston and San Francisco and then returned home to Hawaii. After many years as a hospital-based pediatric physician and full-time faculty member of the John A. Burns School of Medicine, Dr. Rosen has refocused her career in public health and is currently an MPH candidate with Johns Hopkins School of Public Health. Her interests cover a broad range of health issues for women and children.

/2004/ Dr. Rosen was appointed the DOH Deputy for the Health Resources Administration in April 2003. The position is now under recruitment. //2004//

/2005/ Dr. Cynthia Goto has been in the FHSD Medical Director position for the past year. Dr. Goto received a Masters degree in Physiology and Doctor of Medicine from the University of Hawaii John A. Burns School of Medicine. She then completed her residency in Obstetrics and Gynecology and is Board certified in Obstetrics and Gynecology. Dr. Goto was in private practice for 16 years before joining FHSD as medical director. She has also functioned as the Hawaii American College of Obstetricians and Gynecologist (ACOG) Chapter President, thus improving the level of collaboration with the Ob-Gyn community. //2005//

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

The Title V program participates in a network of coalitions, advisory groups and coordination efforts throughout the state. Within the Department of Health (DOH), 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. Title V also collaborates with other state departments: the Department of Education (DOE), Department of Human Services (DHS), Judiciary, the Office of Children and Youth in the Governor's Office.

//2005/ The Office of Children and Youth located in the Governor's Office has been eliminated. Most issues relating to children and youth are now addressed by the Lieutenant Governor's Office. //2005//

DEPARTMENT OF EDUCATION

Hawaii has a single unified public school system serving kindergarten to grade 12. Over 185,000 students are enrolled in public schools, roughly 85% of all students enrolled in educational institutions. DOE reports 50% of Hawaii students in public schools have additional service needs because of disadvantaged economic circumstances, limited English proficiency, or need for special education services. Working with the DOE provides DOH a tremendous opportunity to reach most of the state's youth and those in greatest need.

//2005/ Enrollment in public schools declined slightly in 2002-03 to 182,798 representing 82.5% of school age children (16% are enrolled in private schools, another 1.5% in charter schools). //2005//

The Maternal Child Health Branch (MCHB) works with DOE to implement the provisions of a Memorandum of Agreement that provides funding from the Hawaii Tobacco Settlement Special Funds for a Coordinated School Health Program designed to improve the health of public school children. Title V also provides assistance to the DOE Peer Education Program located in 26 high and middle schools to help students develop healthy lifestyles especially in the areas of prevention of sex assault, violence, teen pregnancy, teen suicide, substance abuse, STD, and AIDS. Title V also organized and participates in an interagency committee to assure the major school health surveys are implemented and funded.

//2005/ Title V participates in the DOE-DOH Comprehensive School Health Program (CSHP) infrastructure development collaborative funded through a cooperative agreement with Centers of Disease Control and Prevention. The purpose the grant is to establish interagency leadership to support the implementation and sustainability of the CSHP. //2005//

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

- a) EIS uses funding from a State Improvement Grant (SIG) to support training activities.
- 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.
- e) EIS collaborates with the DOE and DOH/Child and Adolescent Mental Health Division on service testing for children from birth to 20 years old. This is a methodology to "test" whether children are learning/developing appropriately, and whether the system performs in such a way as to support the growth, development, and education of children.

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)

DHS houses programs critical to the health and welfare of the state MCH population including Medicaid, Temporary Assistance to Needy Families, Food Stamps, Child Welfare Services, Disability Determination, Vocational Rehab, Child Care Services, and Youth Services Programs. Title V collaborates with DHS to improve services to the State's families and children.

DHS provides funding support for EIS through Memoranda of Agreement, for the following:

- a) DHS provides reimbursement through an Early Intervention carveout for QUEST-eligible infants and toddlers who are developmentally delayed or biologically/environmentally at risk.
- b) Inclusion Project provides tuition support for infants/toddlers with developmental delays to participate in child care or community-based program.
- c) 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 partial 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. Collaboration with DHS programs includes child welfare/safety issues through projects like the Blueprint for Change, Title IVB Advisory groups, the Community Based /Family Resources and Support (CBFRS) Program and the Child Death Review. Recently, 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.

//2005/ The Community Based /Family Resources and Support (CBFRS) Program has been renamed to the Community Based Child Abuse Prevention Program (CBCAP). MCH Branch is partnering with the DHS Temporary Assistance for Needy Families (TANF) and the Lieutenant Governor's Office to develop non-school hour programs for middle schools in eight school districts to reduce teen pregnancy and promote healthy youth development. An interagency task force has been formed to coordinate services provided by DHS Child Welfare Services and DOH Healthy Start that targets families at-risk for child abuse. //2005//

Families that qualify for DHS services (Food Stamps, Temporary Assistance to Needy Families 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 follow.

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 under age 7 years, early intervention providers, legislators, pediatrician, and representatives from the DOE, DHS, University of Hawaii (UH), and health insurance.

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 and voicing its concerns about enhancing the work environment and improving the recruitment and retention of qualified special education teachers and other support staff. The Council is working with the DOE in its implementation plan for a Comprehensive Student Support System (CSSS) and school-based mental health services, training initiatives, and assuring that educational needs of special education students within the Justice System are being addressed.

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 committee advised on the expansion of newborn screening from 7 to over 25 disorders, to begin September 2003.

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 Committee advised on the legislative proposal to establish the HBDP in the DOH, and wrote testimony in support of the bill during the 2002 Legislature.

The Folic Acid Committee includes the March of Dimes, Healthy Mothers Healthy Babies, Mothers Care, HBDP, DOH/WIC Branch and Genetics Program, University of Hawaii (UH), Shriners Hospital for Children, American College of Obstetricians and Gynecologists, and other agencies to collaboratively increase awareness of folic acid. A brochure "Folic Acid -- Eating for a Healthier Future" was translated to 4 other languages and distributed to clinics and physicians offices. Funding is from the March of Dimes.

The State Genetics Advisory Committee consists of representatives from public health, health care organizations, consumers, laboratories, March of Dimes, and insurance. 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, Hawaii Early Childhood Hearing Detection and Intervention 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, pediatric audiologists, DOH/Office of Health Status Monitoring, DOH/Health Information Systems Office, and others.

Hawaii Community Genetics is a partnership of DOH/CSHNB, Kapi?olani Medical Center, Queen's Medical Center, UH School of Medicine, and Hawaii Medical Services Association, to develop genetics/metabolic services in Hawaii. Stanford Medical Center is being contracted to provide genetics clinics for metabolic, general pediatric, and adult patients for one week each month in Hawaii; weekly telemedicine clinic; phone coverage for metabolic emergencies; and genetics education for medical students, medical residents, and health providers. Each partner is committing funding and in-kind services. The collaborative group will continue to work toward recruiting a full-time pediatric geneticist for Hawaii.

The Improving Outcomes for CSHCN/Champions for CSHCN is a committee which includes the Tri-Regional Workshop State Team, Participatory Action Team developed through the Measuring and Monitoring Community-Based Systems of Care for CSHCN (M&M) project, and other key state/community partners. Its focus is on improving outcomes for CSHCN. It is using Hawaii data from the National Survey of CSHCN and other local sources as a basis for further planning. The committee includes CSHNB, Family Voices, Public Health Nursing, Vocational Rehabilitation, Developmental Disabilities Division, Developmental Disabilities Council, Dyson Initiative, Medical Home Implementation Project, AAP-Hawaii Chapter, and UH Department of Pediatrics. The M&M project is supporting/assisting CSHNB in this effort.

//2005/ Support/technical assistance has transferred from the M&M Project to the Champions for Progress Center. The core team of CSHNB, Family Voices, and the UH Department of Pediatrics continue to work closely together in planning and involving key partners in collaborative efforts toward achieving the six outcomes for CSHCN. //2005//

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 Hawaii Teen Pregnancy, Prevention and Parenting Council (HTPPC) has continued since 1980 to meet quarterly as 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. Efforts are being taken in HTPPC activities (meetings, trainings) to be inclusive of Laulima In Action, the Hawaii Adolescent Wellness Plan, (and Healthy People 2000/2010 goals) in state and community-based efforts.

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, Act 369 of the Hawaii Revised Statutes, authorized the DOH to conduct child death reviews through standardized procedures to identify causes of death and recommend policies and strategies to prevent future deaths. The Child Death Review Council, with broad representation from the private and public

sector, oversees the development and implementation of this system of services.

Hawaii Children's Trust Fund (HCTF) established by the Legislature (Chapter 350B, Hawaii Revised Statutes) is a public-private partnership committed to establishing a permanent endowment fund to provide grants towards efforts to strengthen families, prevent child abuse and neglect, and promote healthy child development. The HCTF is composed of three entities. The Coalition consists of over 90 individuals, which includes parents, public and private agencies, and other groups with an interest in child abuse prevention. The Advisory Committee is comprised of public and private sector representation, which includes the DHS, DOH, DOE, Office of Youth Services, and the Judiciary. Also sitting on the Advisory Committee are parents, attorneys, and non-profit organizations. The Advisory Board is made up of private and public representatives appointed by the Governor.

Keiki Injury Prevention Coalition (KIPC) is an organization of over 60 private and public partners in the community, including KIPC chapters on Kauai, Maui, and Hawaii. Title V staff continue to provide leadership and participate in statewide activities to address issues related to childhood injury prevention. KIPC supports networking with agencies and community organizations to effect legislation, policy, and educational measures to reduce both unintentional and intentional injuries. Projects include establishing car safety restraint training and checkup sites, sharing pedestrian safety data to targeted schools, and collaborating with the DOE to provide an integrated injury prevention curriculum. KIPC is also the Hawaii Safe Kid's affiliate and participates with the Department of Transportation in the Safe Communities Initiative.

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.

//2005/ 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. //2005//

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 cross-cultural educational materials for pregnant women, including the "Healthy and Hapai (Pregnancy)" calendar 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 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 Program Development Division to coordinate advocacy efforts and program planning.

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 Oahu Nutrition Coalition develops a nutrition strategic plan for Oahu for the Tobacco Advisory Committee to make decisions on the utilization of the Tobacco Settlement funds for nutrition initiatives. There are similar coalitions on each of the neighbor islands. Members range from state agency representatives to those from private businesses.

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 provides important technical and research assistance to the MCH community and are often contracted to conduct research and evaluations for MCH programs.

F. HEALTH SYSTEMS CAPACITY INDICATORS

The Health Systems Capacity Indicators (HSCI) measure the capacity of 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 Health Status Indicator measures (HSI) with a few exceptions.

HSCI #01 The rate of children hospitalized for asthma (10,000 children less than 5 years of age). 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 denominators for 2001 & 2002 are provisional FHSD population estimates based on the 2000 U.S. Census and will be updated once population estimates are released by the Census Bureau.

//2005/ Data reported for 2003 is provisional and does not include data from one major provider on the island of Kauai. The data will be updated next year for all providers. The annual population estimates produced by the U.S. Census Bureau are usually used in reporting population based data for the State of Hawaii; however, due to the unexpected delays in the releasing of the state age-sex population estimates for 2003, a DOH/FHSD population estimation was utilized.

The 2002 estimate reported last year was revised with 2002 hospital data. The indicator data for 2001 and 2002 was updated with the U.S. Census Bureau's age-sex population estimates that were not yet released at the time of last year's application report. The rate excludes newborns, pregnancy-related admissions and patients admitted through a transfer from another facility. //2005//

HSCI #02 The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

Data for this measure comes from the Med-QUEST Division (MQD), the Medicaid agency in the State Department of Human Services (DHS). FY 2002 data is an estimate based on previous year's screening rates since EPSDT data was not provided by MQD at the time of publication. EPSDT data should be forthcoming.

Securing Medicaid data and information has been a challenge over the past year despite repeated requests. The reasons for this problem are unclear. However, Title V is aware that MQD recently established a new management information system, accepted the resignation of a key research officer, has been burdened with HIPPA compliance activities, and transitioned to a new fiscal intermediary for processing of fee-for-service Medicaid claims.

Since 1994 when Hawaii's Medicaid managed care demonstration waiver was approved, MQD has struggled to develop an information system for the new program. After 3 years of problems and setbacks, MQD terminated its contract with Unisys to develop the new system after the company acknowledged the difficulty of the project. Without the requisite information system necessary to manage the demonstration project, DHS elected to pursue a unique partnership with the state of Arizona to contract for information systems support. The partnership proved feasible since Hawaii's managed care program was modeled after Arizona's and Arizona possessed an approved, functional Prepaid Medical Management Information System (PMMIS).

In 1999, DHS contracted with the Arizona Health Care Cost Containment Systems Administration to adapt its existing system to accommodate Hawaii's requirements. Arizona maintains the new HAPA (Hawaii Arizona PMMIS Alliance) system. HAPA is the first example of a state-to-state partnership to develop a management information system. The Hawaii system (HPMISS) was implemented in November 2002. Soon after this date, the MQD Research Officer left his position which remains vacant. The Research Officer is responsible for Quality Review including compiling EPSDT and HEDIS reports.

Title V will continue to aggressively pursue data from MQD.

//2005/ Data for FY 2002 was updated from last year's estimate based on the FY 2002 HCFA-416 Annual EPSDT Participation report. Data for FY 2003 was not available at the time of this report, but is expected soon. Historically, Hawaii has had a high percentage of Medicaid enrollees under the age of one year receiving at least one initial EPSDT periodic screen. //2005//

HSCI #03 The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.

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 2001-2003 are estimates. It is unclear whether the new HPMISS system will be able to provide this information in the future. Title V will continue to request this information.

HSCI #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% on the Kotelchuck Index. FY 2002 is provisional since the final birth record file is not complete. The data indicates the adequacy of prenatal care visits have remained relatively stable over the prior 5 years.

//2005/ FY 2002 data was updated with the final birth record file. FY 2003 data is provisional. Adequacy of prenatal care visits remains stable, with little variation, similar to early entry into prenatal care rates. The reason for this is unclear at this time. Analysis of available data as part of the MCH 5 year needs assessment currently underway may yield some valuable

information for program planning. //2005//

HSCI #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

Medicaid linkage with vital statistics has not been achieved at this time, thus the Medicaid/Non-Medicaid comparison data is not complete. Estimates are available for the percentage of low birth weight infants and infant deaths comparisons using Medicaid data on the number of infants receiving low birth weight services and infant deaths. The Medicaid numbers were subtracted from the State total of LBW infants and infant deaths provided by vital statistics records. The vital statistics data is provisional, however. For both measures, outcomes for Medicaid infants were slightly poorer than for the non-Medicaid infants. Title V will continue to request Medicaid prenatal care data to generate estimates for the last 2 perinatal comparison measures for this indicator.

Linkage discussions with the Medicaid agency will continue through work funded by the federal MCH Bureau State Systems Development Initiative (SSDI) grant.

//2005/ Medicaid data for the perinatal health measures was not available for the report. Title V is arranging meetings with representatives from the Medicaid agency to address the problem. //2005//

HSCI #06 The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.
Eligibility requirements for Medicaid and SCHIP remain the same.

HSCI #07 The percent of EPSDT eligible children 6 through 9 years who have received any dental services during the year.
Preliminary data from Medicaid was provided. The current EPSDT HCFA 416 form was not available at the time of this report. Title V will continue to request the information and update this measure when data becomes available.

//2005/ Data for FY 2002 and 2003 is from a data printout titled "Unduplicated Number of Recipients Receiving Dental Services by Age & Ethnicity" provided by the Medicaid agency. Although FY 2002 EPSDT data is available from the HCFA 416, the numbers do not reflect participation rates reported in previous years and may be a result of a data issue rather than a significant change in service utilization. Title V will address this data issue in future meetings with Medicaid staff. //2005//

HSCI #08 The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program.
Data for this indicator is provided from CSHN Branch and shows a slight decrease of children reportedly receiving services.

//2005/ The percent of SSI beneficiaries increased slightly this year. The reason for this is unclear at this time. //2005//

HSCI #9A The ability of States to assure that the maternal and Child Health program and Title V agency have access to policy and program relevant information and data.

ANNUAL DATA LINKAGES

Data linkage for infant birth and infant death certificates currently occurs for infants one year old and younger through the DOH Office of Health Status Monitoring, the vital statistics agency. The State

Vital Statistics law says that birth certificate data can be used for research purposes only without identifiable information. To make the linkage a regular activity, OHSM and CSHNB are awaiting a written opinion from the State Attorney General's office. To assure all newborns are screened in the State, CSHNB would like to use vital statistics information to identify parents whose infants have not been screened. However, this will require a change in policy. Discussions will continue regarding this issue.

Currently, linkage between birth records and Medicaid and WIC does not occur. Using the federal State Systems Development Initiative (SSDI) grant, Title V was able to convene a Data Linkage Project Team, composed of administrators from the Office of Health Status Monitoring, the MedQUEST Division (MQD), WIC and the Hawaii Health Information Corporation. The Team had been meeting regularly through August 2002, however, meetings are currently on hold to await the AG's legal opinion regarding linkage issues. In the meetings, MQD expressed an interest in data linkage, however raised several concerns including confidentiality requirements. Discussions will resume upon receipt of the AG opinion which is due by the end of July 2003.

WIC has expressed interest in linking eligibility files with birth records. To link WIC and birth records will require WIC to secure written consent from their clients to release the data for purposes of conducting research. WIC will need to create a procedure to secure the consent, integrate the consent information into their management information system, and train WIC staff on the new procedure. This linkage will be a major focus for the SSDI grant in FY 2004.

//2005/ In September 2003, after a delay of nearly 1.5 years, the Department of Health (DOH) received the State Attorney General's (AG) response on linking birth certificate files with newborn screening records. The AG's opinion established the legality of linking these databases and indicated that linkage could occur either at the Office of Health Status Monitoring (OHSM) or at Children with Special Health Needs Branch (CSHNB). To ensure confidentiality of vital records, OHSM requested that linkage occur at OHSM and CSHNB agreed. Meetings have occurred to plan the formal regular linkage process which should occur in summer 2004. The AG's opinion stated that the linked dataset cannot be used to identify and follow-up with parents whose infants have not been screened.

With the receipt of the AG's opinion, the WIC program has agreed to a pilot project using birth certificate files and selected WIC data. Planning meetings are occurring between WIC and OHSM. A special client consent form regarding data linkage has not been implemented and will not be a barrier for the pilot project.

Discussions with Medicaid have been re-opened since the AG's opinion was received. However, the former Medicaid Director has left her position and a replacement has not been named. A Medicaid representative will attend the next Data Linkage Project Team meeting in August 2004. //2005//

REGISTRIES AND SURVEYS

As noted earlier, hospital discharge data is available upon request from Hawaii Health Information Corporation (HHIC). The DOH-Public Health Informatics Project is working with the HHIC to place hospital discharge data in the DOH data warehouse which is currently under development.

Hawaii is one of the few states that maintains a population-based active surveillance system for birth defects through the Hawaii Birth Defects Program. HBDP is funded through a contract administered by the CSHNB. Starting in FY 2004, the SSDI project will work to obtain direct access to the HBDP database. Possible ways to get direct access include obtaining Institutional Review Board (IRB) approval for a research project, IRB waiver for a project related to program services or aggregate data, etc. The law regarding birth defects will need to be studied, and the State Attorney General's opinion will be obtained if necessary. With the help of Title V program staff, the SSDI project will develop an analysis and implementation plan for this database.

The MCH Branch within the Title V agency conducts the Pregnancy Risk Assessment Monitoring System (PRAMS) annually. FY 2000 represents the first full year of data from the survey.

//2005/ The DOH Informatics Project and the Hawaii Health Information Corporation (HHIC) are no longer partners in the development of the DOH data warehouse. Therefore, HHIC's hospital discharge data will not be placed in the data warehouse and will not be available for linkage.//2005//

HSCI #9B The ability of States to determine the percent of adolescents grades 9 through 12 who report using tobacco products in the past month.

Since 1989, the Youth Risk Behavior Survey (YRBS) has been administered every two years in the Department of Education in collaboration with the University of Hawaii and the Centers for Disease Control and Prevention. The University of Hawaii, Curriculum Research and Development Group has been contracted to administer the YRBS in Hawaii from 1993 to the present. The Title V Program has taken the lead in organizing and facilitating an Adolescent Survey Committee (ASC) to assure that the YRBS is implemented and funded. The ASC has focused in recent years on coordinating the administration of all the school health surveys (i.e. tobacco, substance use, and health curriculum) to alleviate the burden on the schools.

The SSDI Project will collaborate with ASC to obtain direct access to the YRBS database. With the help of Title V program staff, the SSDI project will develop an analysis and implementation plan for this database.

//2005/ The ACS continues to focus efforts on designing an effective coordinated process to administer the various school health surveys. The process utilized in 2003 did not produce the response rates needed to generate weighted data and is being evaluated and modified for the 2005 school year. //2005//

HSCI #9C The ability of States to determine the percent of children who are obese or overweight. YRBS data on overweight/obesity adolescents is available (see HSCI 9B) and is monitored as a Title V state performance measure. The Hawaii WIC program tracks data on weight for clients from birth to 5 years. Title V has direct access to this data. The WIC child weight data is submitted to the national Pediatric Nutrition Surveillance System dataset at the Centers for Disease Control (CDC). Title V does not have direct access to the PedNSS dataset, but can access summary reports provided by CDC.

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 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 the 10 state MCH priorities selected in FY 2001, the Title V agency revised the list of state performance measures, deleting six existing measures for FY 2001-2005 and selecting six new state measures, for a total of 10 measures. Figure 11 State Performance Measures lists all the state measures including those that were discontinued and the new added measures. The new state measures are numbered 11 to 16. Detail sheets have been developed for the six new measures (see Form 16) and 5-year projections for FY 2001-2005 can be found in Form 11.

In FY 2002, Hawaii met or exceeded its Annual Performance Objectives for 6 of the 12 National Performance Measures (the 6 new Children with Special Needs measures were excluded since there were no objectives set for the measures) and met or exceeded its Annual Performance Objectives for 5 of the 10 State Performance Measures. Hawaii met or exceeded 6 Healthy People 2010 objectives for measures with numerical targets and contributed to meeting 11 HP 2010 objectives without numerical targets.

/2005/ In FY 2003, Hawaii met or exceeded its Annual Performance Objectives for 6 of the 12

National Performance Measures (the 5 Children with Special Needs measures that rely of the national CSHN survey were excluded and PM 09 had no data for a second year and was not included in the total) and met or exceeded its Annual Performance Objectives for 5 of the 10 State Performance Measures. Hawaii met or exceeded 5.3 Healthy People 2010 objectives for measures with numerical targets and contributed to meeting 5 HP 2010 objectives without numerical targets. //2005//

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. Report revisions and recommendations for improvement to the following year's application are identified. The report revisions were submitted in January 2003. The recommendations for the FY 2002 report concern 4 areas.

1. Title V Program Capacity Issues:

- a. Current position vacancies are discussed in Part III D Other (MCH) Capacity
 - b. The plan for use of the unobligated balance is discussed in the Section VB Budget.
 - c. Technical assistance needs around epidemiology and data interpretation for workforce development is captured in Form 15 and discussed in State Performance Measure 15.
 - d. A description of outcomes/accomplishments from collaboration with Department of Human Services and Department of Education is discussed throughout the report in Section III E State Agency Coordination as well as in National and State performance measure narratives.
2. The summary of Title V measures, data, priorities and significant activities was not completed. It is unclear at this time whether this project is a priority for Title V.

3. The progress of Title V in addressing oral health needs of the MCH population is discussed in the narrative for National Performance Measure 9 (child dental sealants) and NPM 15 (very low birth weight).

4. Corrections for Forms:

- a. Form 8 includes race data on population eligible for Title XIX in this year's application
- b. Form 7 See notes for efforts to secure separate reporting data for Medicaid and SCHIP individuals.

5. A discussion of the relationship between performance and outcome measures in not included in this year's report since Outcome measure reporting is now optional during interim year's between needs assessments. This discussion will be included in the 2005 Title V report as part of the 5-year needs assessment.

//2005/ There were no requirements or recommendations for FY 2003. //2005//

B. STATE PRIORITIES

Ten priority issues were identified through the Maternal and Child Health five year needs assessment. These priorities are to be the programmatic focus areas for FHSD working in partnership with other agencies/programs through 2005. 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) and 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:

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.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

One hundred percent of infants who were screened and confirmed with mandated newborn screening disorders received appropriate follow-up. Until August 31, 2003, Hawaii's newborns were screened for seven disorders. On September 1, 2003, the newborn screening testing panel was expanded to 31 disorders. Additional urea cycle, organic acid, fatty acid oxidation and other amino acid disorders are now being screened with the use of a new technology called tandem mass spectrometry. (See Form 6.)

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 not screened. For infants who were confirmed with disorders, the 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 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 feeding history. Birthing facilities used these screening practice profiles as a quality assurance tool. Updated information on newborn metabolic screening is provided on the Genetics Program/DOH website.

NBMSPP participated in an 18 month pilot tandem mass spectrometry study which ended on August 31, 2003, with the California Genetic Disease Branch, Kapiolani Medical Center for Women and Children (KMCWC), and the Oregon State Public Health Laboratory. During the pilot study, an infant with isovaleric acidemia was detected and treated.

NBMSPP also participated in a federal grant on the financial, ethical, legal, and social issues

(FELSI) surrounding tandem mass spectrometry in newborn screening. The project is using a multi-state collaboration to identify strategies and develop educational materials for a culturally and ethnically diverse population.

On October 21, 2002, the NBMSAP Advisory Committee recommended expanding mandated screening to include the additional disorders which could be identified through tandem mass spectrometry and to raise the newborn screening fee from \$27 to \$47. To implement this change, NBMSAP revised the Newborn Screening Administrative Rules; conducted public hearings; modified the contract with the central laboratory; conducted statewide in-service sessions at the birthing facilities for physician, nursing, and laboratory staff, childbirth educators, public health nurses, midwives and perinatal groups such as Health Mothers/Healthy Babies; revised and distributed the Newborn Screening Practitioner's Manual and parent brochures statewide to health practitioners including obstetricians.

b. Current Activities

NBMSAP continues its oversight over the newborn metabolic screening system: obtaining blood specimens at hospitals, specimen transport, central laboratory testing, physician notification, and tracking. For infants who were confirmed with disorders, the NBMSAP continues to identify the medical home, link the medical home with the metabolic consultants, and follow-up with the medical home to ensure timely treatment. The transition to expanded newborn screening of 31 disorders went very smoothly and was well accepted by the community.

The closure of the Queen's Medical Center Metabolic Clinic led to a "Hawaii Community Genetics" (HCG) partnership of the DOH/CSHNB, Kapiolani, Queen's, UH School of Medicine, and HMSA, to develop genetic/metabolic services. A contract was arranged with Stanford Medical Center for a geneticist to travel to Hawaii for one week per month to hold genetic clinics for metabolic, general pediatric and adult patients; phone coverage for metabolic emergencies; and genetics education for medical students, medical residents, and health providers. NBMSAP is committing at least \$50,000 of its special funds to support HCG. CSHNB is contributing in-kind staff for medical nutrition therapy, nursing, and genetic counseling services several days per month. The collaborative group will continue to work toward recruiting a full-time pediatric geneticist for Hawaii.

On October 3, 2003, NBMSAP received the Deputy Attorney General's interpretation of Section 338-28, Hawaii Revised Statutes, relating to the sharing of birth certificate data with NBMSAP and the Newborn Hearing Screening Program. According to the interpretation, the Office of Health Status Monitoring cannot provide any birth certificate data other than name, sex, and type of vital event for quality assurance or other public health purpose that is not considered "research". Therefore, NBMSAP can no longer contact the home birth parents to inform them of mandated newborn metabolic screening; nor can there be any matching of birth certificate data with newborn screening data.

The number of home births without screening is now unknown. There is a great potential for missed and/or delayed diagnosed cases in the home birth population. In an effort to improve outreach to home birth parents, NBMSAP conducted an educational session on the importance of newborn metabolic screening for midwives at their Midwifery Conference on 11/14/03. To increase access to screening, NBMSAP is also giving newborn screening kits without charge to midwives.

NBMSAP continues to participate in the FELSI grant. Fourteen consumer focus groups were held in four Western states (HI, AL, CA, and OR) to elicit parental opinions about the informational process and products needed to educate parents about newborn screening. Information obtained from the focus groups were used to develop model educational materials that were used as part of a survey of Baby Expo participants in two states (HI and CA).

c. Plan for the Coming Year

For infants who were confirmed with disorders, the NBMSP will continue to identify the medical home, link the medical home with the metabolic consultants, and follow-up with the medical home to ensure timely treatment. 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 improve their newborn screening practice profiles through monthly reports and in-service sessions.

NBMSP will continue to participate in the FELSI grant, which will continue until May 2005. Project activities include: research consumer attitudes and needs as related to FELSI; develop culturally competent, understandable, and translated model educational materials for consumers and health care providers.

NBMSP will continue its participation in other CSHNB grants involving data integration and data linkages with such programs as Newborn Hearing Screening, Early Intervention, and Children with Special Health Needs Program.

NBMSP will continue to participate in the Hawaii Community Genetics collaborative group and advocate for improved coordination of follow-up care once a child has been screened and diagnosed.

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)

a. Last Year's Accomplishments

A Family Voices leader was a member of the State Team for the Tri-Regional Workshop (Regions VIII, IX, X) in February 2003 in Portland, Oregon, on "Building Systems of Care for Children and Youth with Special Health Care Needs". The Team developed a plan for the six outcomes for CSHCN. Follow-up included reviewing and updating the Hawaii plan/progress to achieve the six goals.

A committee to improve outcomes for CSHCN included the participatory action team developed through the Measuring and Monitoring Community-Based Systems of Care for CSHCN (M&M) project, and other state/community partners. Members included Family Voices, DOH/CSHNB,

DOH/Developmental Disabilities Division, DOH/Public Health Nursing Branch, Department of Human Services/Division of Vocational Rehabilitation, State Council on Developmental Disabilities, Dyson Initiative, Medical Home Implementation Project, University of Hawaii (UH)/Department of Pediatrics, and American Academy of Pediatrics (AAP)-Hawaii Chapter. The committee reviewed initial Hawaii data from the National Survey of CSHCN and other Hawaii data relating to the six outcomes for CSHCN, including family partnership.

A Family Voices leader is one of the Co-Principal Investigators (Co-P.I.) for the Hawaii Medical Home Implementation Project, which began planning in April 2002 for a Medical Home conference held in February 2003. A family's story was videotaped and shown as part of the session on "Comprehensive, Coordinated, Family-Centered Collaborative Care", which was co-facilitated by the Family Voices Co-P.I. Families attended this conference.

The Hawaii Early Intervention Coordinating Council includes at least 20% (3/15) of members who are parents of infants, toddlers, or children with special needs under age 7 years.

Early Intervention Section (EIS) involves parents in training and/or mentoring activities, as members of committees, and on interview panels for EIS positions. Parents are invited to all training activities sponsored by EIS at no cost, and are also financially supported (stipend to cover cost of child care, and airline coupons/ground transportation as needed) to attend both general conferences and specific trainings sponsored by other agencies. Parents are participating in the U.S. Department of Education's Office of Special Education Programs monitoring of Hawaii's Part C program. EIS includes "parent of a child with special needs" as a desired qualification in each staff position description.

Parents of children with metabolic disorders serve on the Newborn Metabolic Screening Advisory Committee, which advised on the expansion of newborn metabolic screening to at least 25 disorders, using tandem mass spectrometry, which began September 2003.

Healthy Child Care Hawaii Advisory Team includes parents of young children in child care.

The Early Hearing Detection and Intervention Advisory Committee includes individuals with hearing loss and parents of children with hearing loss.

b. Current Activities

Families continue to be involved in various ways, including councils, task forces, and advisory committees; development and review of parent 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 stipends, airline coupons and ground transportation for Neighbor Island families, and child care during activities. Family participants are of diverse ethnic and cultural backgrounds. Families will continue to be involved in councils and advisory committees, including Hawaii Early Intervention Coordination Council, EIS Office of Special Education Monitoring Task Force, Newborn Metabolic Screening Advisory Committee, Early Hearing Detection and Intervention Advisory Committee, and Healthy Child Care Hawaii Advisory Team.

The Hawaii Medical Home Implementation Project convened the first series of district meetings in various locations throughout the state, involving physicians, state/community agencies, and families of CSHCN. The Family Voices Co-P.I. facilitated meetings, which looked at strengths, needs/issues/barriers to providing care, and areas where service delivery can be improved. The project is now videotaping 2 more family stories.

The CSHNB Chief attended the Family Voices Regional Workshop (Region IX) in Reno,

Nevada, in February 2004. The meeting focused on data collection, development of leadership and mentoring, improving the youth transition system, serving underserved and under-represented populations, and engaging non-traditional partners.

Hawaii data from the National Survey of CSHCN were analyzed. The report, completed in May 2004, included data on family partnership.

The State Team for the Multi-State Meeting (June 2004) in Snowbird, Utah, included a Family Voices leader, pediatrician representing the AAP-Hawaii Chapter and UH Department of Pediatrics, and the Hawaii CSHCN Title V Director. The meeting provided an opportunity to further develop skills and knowledge regarding collaborative solutions, measurement, and data sources; and develop a collaborative planning approach to achieve outcomes for CSHCN.

As part of the Title V five-year needs assessment for CSHCN, initial meetings are being held on Oahu and the Neighbor Islands (Hawaii, Kauai, Maui) from June-August 2004. Participants include families, Family Voices, and key state and community agencies and organizations. Participants are providing their input on strengths, needs, and opportunities for each of the six outcomes for CSHCN. Participant information from these meeting are being compiled and analyzed.

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. Parents will continue to be compensated or assisted in various ways including stipends, airline coupons and ground transportation for Neighbor Island families, and child care during activities. Families will continue to be involved in Hawaii Early Intervention Coordination Council, EIS Office of Special Education Monitoring Task Force, Newborn Metabolic Screening Advisory Committee, Early Hearing Detection and Intervention Advisory Committee, State Genetics Advisory Committee, Healthy Child Care Hawaii Advisory Team, committee on improving outcomes for CSHCN, Hawaii Medical Home Implementation Project.

As part of the Title V CSHCN needs assessment and planning, families will be involved in reviewing data and information related to the six outcomes, developing priorities and strategies to address needs, and developing a plan of action.

CSHNB will complete the needs assessment for CSHCN, continue meetings with state/community partners, select priority needs related to the outcomes for CSHCN, and will develop a plan to address these priority needs. A core team of Family Voices leaders, pediatrician representing the AAP-Hawaii Chapter and UH Department of Pediatrics, and the Hawaii CSHCN Title V Director will continue to work together toward achieving the outcomes of CSHCN using a collaborative approach.

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)

a. Last Year's Accomplishments

The Medical Home Implementation Project for CSHCN, funded by the MCH Bureau, is a collaborative effort of the American Academy of Pediatrics (AAP)-Hawaii Chapter, Family Voices of Hawaii, and DOH/CSHNB. The Project took the lead in planning the "Every Child Deserves a Medical Home" Training Program in Honolulu in February 2003. Presentations

included: Transitioning Children and Youth to Adulthood; Practices, Policies, and Procedures; and Comprehensive, Coordinated, Collaborative Care which included a family story video developed by the Medical Home Project. There were 149 participants, including physicians, allied health professionals, and parents.

Healthy Child Care Hawaii (HCCH), funded by the MCH Bureau, promotes the health and safety of children in out-of-home child care. It is a collaborative project of FHSD/CSHNB, University of Hawaii (UH) Department of Pediatrics, and AAP-Hawaii Chapter. Activities to promote the medical home included providing information in newsletters and educational sessions for child care providers.

CSHNB participated in developing the Early Childhood Comprehensive Systems grant proposal, which included incorporating the HCCH objectives related to quality assurance, infrastructure-building, and access to medical homes and insurance in the early childhood system plan.

At the Tri-Regional Workshop in February 2003 in Portland, the State Team developed a plan of to address the medical home and other outcomes for CSHCN.

The medical home concept has been incorporated into pediatric resident training. The UH Department of Pediatrics/Integrated Pediatric Residency Program-Hawaii Dyson Initiative offers pediatric residents training that integrates a medical home approach throughout the three years of training.

CSHNB programs incorporated the medical home into program services. For example, for infants who were confirmed with metabolic disorders, the Newborn Metabolic Screening Program identified the medical home, linked the medical home with the metabolic consultants, and followed-up with the medical home to ensure timely treatment.

A committee to improve outcomes for CSHCN included the participatory action team developed through the Measuring and Monitoring Community-Based Systems of Care for CSHCN (M&M) project, and other key state/community partners. It reviewed initial Hawaii data from the National Survey of CSHCN and other Hawaii data relating to the six outcomes for CSHCN, including medical home.

b. Current Activities

The Medical Home Implementation Project convened community meetings with physicians, families of CSHCN, state/community agencies, to identify strengths, needs/issues/barriers to providing care, and how service delivery can be improved. Meetings were held on the islands of Kauai, Hawaii (Hilo, Kona), and Oahu (Waianae, Central, Leeward, Windward). Follow-up includes addressing some of the identified issues and barriers to services.

The Early Childhood Comprehensive Systems (ECCS) planning grant includes a medical home component. For the ECCS conference "Charting the Future: Connecting the Stars for Our Children" in May 2004, CSHNB developed the fact sheet on "Medical Home", and the CSHNB Chief presented data on young CSHCN. The Medical Home Implementation Project Co-Principal Investigator and Coordinator facilitated the breakout session on Medical Home.

The Health and Early Childhood Committee of the State Council for Developmental Disabilities, under an objective to improve community support services, added a new activity to encourage efforts to assure a medical home for every young child with developmental disabilities. This committee includes representatives from the CSHNB, Developmental Disabilities, UH Center on Disability Studies, and DHS Med-QUEST Division.

The pediatric resident training continues to incorporate the medical home concept.

CSHNB programs continue to promote the medical home concept in planning and providing services.

Kamehameha Schools and UH Department of Pediatrics are partnering on planning conferences on developmental screening for pediatricians, other health care providers, early childhood community providers, and key policy makers. The FHSD and CSHNB Chiefs are involved in planning the conference for community partners.

Hawaii data from the National Survey of CSHCN were analyzed. The report, completed in May 2004, included data on medical home.

The State Team for the Multi-State Meeting (June 2004) in Snowbird, Utah, included a Family Voices leader, pediatrician representing the AAP-Hawaii Chapter and UH Department of Pediatrics, and the Hawaii CSHCN Title V Director. The meeting provided an opportunity to further develop skills and knowledge regarding collaborative solutions, measurement, and data sources; and how other states are approaching system-building, and develop a collaborative planning approach to achieve outcomes for CSHCN.

As part of the Title V five-year needs assessment for CSHCN, initial meetings are being held on Oahu and Neighbor Islands (Hawaii, Kauai, Maui) from June-August 2004. Participants include families, pediatricians, and key state and community agencies and organizations. Participants are providing their input on strengths, needs, and opportunities for each of the six outcomes for CSHCN. Participant information from these meeting are being compiled and analyzed.

c. Plan for the Coming Year

The Hawaii Medical Home Implementation Project will continue community meetings with physicians, families of CSHCN, state/community agencies and programs, with the purpose of identifying strengths, needs, and priorities. It will continue to work on improving systems of care and provision of specialty care through linkages with the medical home. Two more videos of family stories are being developed.

Healthy Child Care Hawaii will continue to promote the medical home concept in its information to child care health consultants and to child care programs, and will participate in developing the Early Childhood Comprehensive Systems plan, with FHSD/MCH Branch, focusing on the inclusion of the HCCH objectives related to quality assurance, infrastructure-building, and access to medical homes and insurance.

The pediatric resident training will continue to incorporate the medical home concept.

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

CSHNB will complete the needs assessment for CSHCN, continue meetings with state/community partners, select priority needs related to the outcomes for CSHCN, and will develop a plan to address these priority needs. A core team of Family Voices leaders, pediatrician representing the AAP-Hawaii Chapter and UH Department of Pediatrics, and the Hawaii CSHCN Title V Director will continue to work together toward achieving the outcomes of CSHCN using a collaborative approach.

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)*

a. Last Year's Accomplishments

Program staff provided information and assisted uninsured CSHCN/families in obtaining health coverage from public sources, including: a) QUEST managed care for Medicaid-eligible children; it includes the State Child Health Insurance Program for children with family income less than 200% FPL. b) Fee-for-service (FFS) for Medicaid-eligible children with disabilities. c) QUEST-Net for children who lost QUEST/FFS coverage due to increasing income or assets. d) Immigrant Children's Program for uninsured legal immigrant children who are not eligible for the Medicaid program, with family income less than 200% FPL. e) Home and Community-Based Services waivers.

As a safety net and to increase access to services, Children with Special Health Needs Program (CSHNP) provided medical specialty, laboratory, x-ray, hearing aids, cardiac and neurology clinics on Neighbor Islands, and air/ground transportation. CSHNP assisted in administering the Hawaii Lions Foundation Uninsured/Under-Insured Fund for hearing and vision services. Newborn Metabolic and Newborn Hearing Screening Programs paid for screening and follow-up diagnostic evaluations for families who cannot afford the cost. Preschool Development Screening Program provided developmental and behavioral screening for children who would otherwise not access screening.

Early Intervention Section (EIS) provided psychological, audiological, physical/occupational therapy, speech, nutrition, vision, assistive technology, transportation, and other services for children age 0-3 with or at biological/environmental risk for developmental delays (mandated by Part C of IDEA). EIS administered the DOH respite funding for children age 0-3 years with developmental delays and children age 0-21 years with serious/chronic illness.

Hawaii Covering Kids continued its efforts that began in 1999 toward a seamless enrollment process for children and youth eligible for Medicaid/QUEST. Activities included outreach programs and simplifying the enrollment process.

Hawaii Uninsured Project is a collaborative effort to design workable plans to ensure that all Hawaii residents have access to health care coverage. Project partners include state/local government, health care plans and providers, business, research, and community organizations.

CSHNB raised the issue of underinsurance for hearing aids at meetings of the Keiki Caucus, a group of legislators. This resulted in 2003 legislative bills that proposed mandatory health insurance coverage of hearing aids. These measures had legislative hearings, but none were passed by the Legislature.

A committee to improve outcomes for CSHCN included the participatory action team developed through the Measuring and Monitoring Community-Based Systems of Care for CSHCN (M&M) project, and other key state/community partners. It reviewed initial Hawaii data from the National Survey of CSHCN and other Hawaii data relating to the six outcomes for CSHCN, including health insurance.

b. Current Activities

Health providers and program/agency staff continue to provide information and assist uninsured families in obtaining Medicaid/QUEST and/or other health care coverage.

CSHNB programs continue to provide direct and enabling services as a safety net and to increase access to services, especially for those without other resources. These services include medical specialty and other services (CSHNP); newborn screening and follow-up diagnostic evaluations (Newborn Metabolic and Newborn Hearing Screening Programs); developmental and behavioral screening (Preschool Development Screening Program); and respite services (EIS/Respite Program). EIS continues to provide early intervention services as mandated by Part C of Individuals with Disabilities Education Act (IDEA).

The Hawaii Uninsured Project is continuing to work in partnership with researchers and the community, to support policy-makers as they develop workable plans that will cover the uninsured, and to improve understanding of access, quality, and affordability issues.

Hawaii Covering Kids is continuing its state coalition activities, including conducting and coordinating outreach programs, and simplifying the Medicaid/QUEST enrollment process through a revised application for children and pregnant women.

Hawaii data from the National Survey of CSHCN were analyzed. The report, completed in May 2004, included data on health insurance.

The State Team for the Multi-State Meeting (June 2004) in Snowbird, Utah, included a Family Voices leader, pediatrician representing the American Academy of Pediatrics (AAP)-Hawaii Chapter and UH Department of Pediatrics, and the Hawaii CSHCN Title V Director. The meeting provided an opportunity to further develop skills and knowledge regarding collaborative solutions, measurement, and data sources; and develop a collaborative planning approach to achieve outcomes for CSHCN.

As part of the Title V five-year needs assessment for CSHCN, initial meetings are being held on Oahu and the Neighbor Islands (Hawaii, Kauai, Maui) from June-August 2004. Participants include families, Family Voices, pediatricians, and key state and community agencies and organizations. Participants provided their input on strengths, needs, and opportunities for each of the six outcomes for CSHCN. Participant information from these meetings are being compiled and analyzed.

c. Plan for the Coming Year

Health providers and program/agency staff will continue to provide information and assist uninsured families in obtaining Medicaid/QUEST and/or other health care coverage.

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. These services include medical specialty and other services (CSHNP), newborn screening and follow-up diagnostic evaluations (Newborn Metabolic and Newborn Hearing Screening Programs), developmental and behavioral screening (Preschool Development Screening Program), and respite services (EIS/Respite Program). EIS will continue to provide early intervention services as mandated by Part C of IDEA.

CSHNB will continue to track activities of the Hawaii Uninsured Project and Hawaii Covering Kids.

CSHNB will complete the needs assessment for CSHCN, continue meetings with state/community partners, select priority needs related to the outcomes for CSHCN, and will develop a plan to address these priority needs. A core team of Family Voices leaders, pediatrician representing the AAP-Hawaii Chapter and UH Department of Pediatrics, and the Hawaii CSHCN Title V Director will continue to work together toward achieving the outcomes of CSHCN using a collaborative approach.

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)*

a. Last Year's Accomplishments

CSHNB programs work toward statewide coordinated, family-centered services/systems:

- Early Intervention Section (EIS) is the lead agency for Part C/IDEA mandated early intervention services for infants/toddlers. EIS is responsible for the statewide system, including central directory, public awareness, child find, evaluation/assessment procedures, Individual Family Support Plan (IFSP), personnel development and standards, procedural safeguards, program supervision/monitoring, complaint resolution, financial policies, interagency agreements, and data collection.

- Newborn Hearing Screening Program is responsible for the statewide system of newborn hearing screening and followup, including protocols to assure timely screening, diagnostic audiological evaluation, and link to early intervention services; technical assistance; quality assurance; data/tracking; professional/public education; and evaluation.

- Newborn Metabolic Screening Program is responsible for the statewide system of newborn metabolic screening, including standards and procedures for timely screening, diagnosis, and intervention/followup; data/tracking; quality assurance; and professional/public education. Screening expanded from 7 to 31 disorders, beginning September 2003

- Preschool Developmental Screening Program promotes early identification and intervention for developmental/behavioral problems for children age 3-5 years. The program trains community providers in standardized screening, and assists in follow-up for children with developmental/behavioral concerns.

- Children with Special Health Needs Program provides medical specialty, laboratory, x-ray, nutrition, social work, craniofacial review, pediatric cardiac and neurology clinics on Neighbor Islands, and other services, as a "safety net" and to increase access to services.

Community efforts to improve and/or increase access to services:

- Medically Fragile Coordinating Committee is working toward a seamless continuum of care for medically fragile technology-dependent children.

- Hawaii Covering Kids is working toward a seamless enrollment process for children and youth eligible for Medicaid/QUEST, through outreach and simplifying the enrollment process.

- Hawaii Uninsured Project is a collaborative effort with DOH to ensure that all Hawaii residents have access to health coverage.

- Medical Home Implementation project planned the Medical Home conference held February 2003, to further advance the medical home approach for comprehensive, coordinated, collaborative, family-centered services.

A committee to improve outcomes for CSHCN included the participatory action team developed through the Measuring and Monitoring Community-Based Systems of Care for CSHCN (M&M) project, and other key state/community partners. It reviewed initial Hawaii data from the National Survey of CSHCN and other Hawaii data relating to the six outcomes for CSHCN,

including organization of services.

b. Current Activities

CSHNB programs continue to strive toward statewide coordinated, family-centered services/systems. Early Intervention Section is tracking funding/expenditures to document the increased need for resources to serve the increased number of children needing services, and is implementing its Improvement Plan to address areas of non-compliance with Part C/IDEA. Newborn Metabolic Screening Program expanded newborn screening from 7 to 31 disorders. The Genetics Program is an active partner in the Hawaii Community Genetics effort to develop genetics/metabolic services in Hawaii to fill a void; this is resulting in a contract with Stanford Medical Center for genetics clinics in Hawaii, and genetics education for health care providers.

The Medically Fragile Coordinating Committee continues to work toward a seamless continuum of care for medically fragile technology-dependent children. The committee includes the DOH, Department of Human Services, Kapiolani Medical Center for Women and Children, and other health care organizations. The committee continues to address issues and barriers to services. A Medically Fragile Conference in November 2003 included presentations on national issues/trends in care, assistive technology, case management, and waiver services.

The Medical Home Implementation Project convened meetings with physicians and other community providers in various locations statewide, with discussions centered on strengths, needs, and issues/barriers to care.

Hawaii data from the National Survey of CSHCN were analyzed. The report, completed in May 2004, included data on organization of services. CSHNB, with the University of Hawaii (UH) Department of Pediatrics, is further analyzing the data on organization of services by age, mother's education, family income, severity of child's condition, and other factors which may help in better understanding issues and barriers to services.

The State Team for the Multi-State Meeting (June 2004) in Snowbird, Utah, included a Family Voices leader, pediatrician representing the American Academy of Pediatrics (AAP)-Hawaii Chapter and UH Department of Pediatrics, and the Hawaii CSHCN Title V Director. The meeting provided an opportunity to further develop skills and knowledge regarding collaborative solutions, measurement and data sources; and develop a collaborative planning approach to achieve outcomes for CSHCN.

As part of the Title V five-year needs assessment for CSHCN, initial meetings are being held on Oahu and the Neighbor Islands (Hawaii, Kauai, Maui) from June-August 2004. Participants include families, Family Voices, pediatricians, and key state and community agencies and organizations. Participants provided their input on strengths, needs, and opportunities for each of the six outcomes for CSHCN. Participant information from these meeting are being compiled and analyzed.

c. Plan for the Coming Year

Current collaborative planning efforts will continue, including those for CSHNB programs (Early Intervention Section, Newborn Hearing Screening Program, Newborn Metabolic Screening Program, Preschool Developmental Screening Program, Children with Special Health Needs Program, and Genetics Program), Medically Fragile Coordinating Committee, Medical Home Implementation Project, and committee on improving outcomes for CSHCN. These efforts include provision of services as a safety net for CSHCN and to increase access to services; increasing resources to meet increased need or gaps in availability of services; education/training on services and resources for CSHCN; improving coordination of health, education, social, and other services for CSHCN; collaborative partnerships to address

improving outcomes for CSHCN; needs assessment, including needs, issues, and barriers to care for CSHCN identified by families/communities; and further analysis of the Hawaii data from National Survey of CSHCN regarding access to care and barriers, and publication/dissemination of data.

CSHNB will complete the needs assessment for CSHCN, continue meetings with state/community partners, select priority needs related to the outcomes for CSHCN, and will develop a plan to address these priority needs. A core team of Family Voices leaders, pediatrician representing the AAP-Hawaii Chapter and UH Department of Pediatrics, and the Hawaii CSHCN Title V Director will continue to work together toward achieving the outcomes of CSHCN using a collaborative approach.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

a. Last Year's Accomplishments

Transition begins in early childhood. Early Intervention Section (EIS) provided transition training to EIS staff, Department of Education (DOE) Preschool Special Education and Student Support Coordinators, Head Start, Healthy Start, community preschools, and family members. The Early Intervention Orientation included one day on transdisciplinary service provision, teaming, and transition. EIS staff provided transition planning and services/supports for children with developmental delays exiting from Part C early intervention services.

EIS care coordinators provided information and assistance with Supplemental Security Income (SSI) referral to families of children age 0-3 with developmental delays. Families of children who may qualify were given information about SSI and how to apply. Care coordinators assisted families in applying for SSI if requested.

Social workers and other health professionals in the Children with Special Health Needs Program (CSHNP) provided outreach services to medically eligible SSI applicants less than age 16 years referred by the Disability Determination Branch of the Department of Human Services (DHS), and to SSI beneficiaries referred by other community resources.

The February 2003 "Every Child Deserves a Medical Home" training included a session on Transitioning Children and Youth to Adulthood, which covered barriers to successful transition to work, independence, and adult health care; strategies and promising practices to overcome these barriers; and assisting youth to obtain services and resources to transition from pediatric to adult health care and school to work. A CSHNB display table included informational sheets and checklists for providers and families on the transition to adult health care.

Several CSHNP staff meetings focused on the transition to adult health care, work, and independence, with information/discussion of transition issues, planning, tools, and Hawaii data.

Transition services were provided for special education students in the Department of Education. Beginning at age 14, the Individualized Education Plan (IEP) includes the student's transition service needs that focus on courses of study. Beginning at age 16, the IEP includes needed transition services, and interagency responsibilities or linkages.

The University of Hawaii (UH)/School of Medicine has a combined Internal Medicine/Pediatrics residency program. This helps to increase the number of physicians able to provide services for individuals of all ages, including youths with special health care needs transitioning to adult health care.

A committee to improve outcomes for CSHCN included the participatory action team developed through the Measuring and Monitoring Community-Based Systems of Care for CSHCN (M&M) project, and other key state/community partners. It reviewed initial Hawaii data from the National Survey of CSHCN and other Hawaii data relating to the six outcomes for CSHCN, including transition to adult life.

b. Current Activities

EIS continues to provide and/or assist with transition training. The three-day Early Intervention Orientation includes one day of information on transdisciplinary service provision, teaming, and transition; this training is provided for early interventionists, public health nurses, and Healthy Start providers. EIS staff continue to provide transition planning and services/supports when children exit from Part C early intervention services, and continue to provide information and assistance to families with SSI referral.

CSHNP social workers and other health professionals continue to provide outreach services to medically eligible SSI applicants less than age 16 years referred by DHS Disability Determination Branch, and to SSI beneficiaries referred by other community resources.

Transition services continue to be provided for special education students in the DOE.

The UH Internal Medicine/Pediatrics residency program continues its training.

The State Team for the Multi-State Meeting (June 2004) in Snowbird, Utah, included a Family Voices leader, pediatrician representing the American Academy of Pediatrics (AAP)-Hawaii Chapter and UH Department of Pediatrics, and the Hawaii CSHCN Title V Director. The meeting provided an opportunity to further develop skills and knowledge regarding collaborative solutions, measurement and data sources; and develop a collaborative planning approach to achieve outcomes for CSHCN. The State Team is considering a focus on transition for future planning and activities.

Hawaii data from the National Survey of CSHCN were analyzed. The report, completed in May 2004, included data on transition.

As part of the Title V five-year needs assessment for CSHCN, initial meetings are being held on Oahu and the Neighbor Islands (Hawaii, Kauai, Maui) from June-August 2004. Participants include families, Family Voices, pediatricians, and key state and community agencies and organizations. Participants are providing their input on strengths, needs, and opportunities for each of the six outcomes for CSHCN. Participant information from these meetings are being compiled and analyzed.

c. Plan for the Coming Year

EIS will continue to provide information and assistance to families with SSI referral, and provide transition planning and services/supports for children exiting from Part C early intervention services. Transition training will continue.

CSHNP social workers and other health professionals will continue to provide outreach services to medically eligible SSI applicants less than age 16 years referred by DHS Disability Determination Branch, and to SSI beneficiaries referred by other community resources. CSHNP will continue to include a focus on the transition to adult health care, work, and independence, and to include transition planning in staff services with youth/families.

Transition services will continue to be provided for special education students in the

Department of Education.

The UH Internal Medicine/Pediatrics residency program continues its training of physicians.

CSHNB will complete the needs assessment for CSHCN, continue meetings with state/community partners, select priority needs related to the outcomes for CSHCN, and will develop a plan to address these priority needs. A core team of Family Voices leaders, pediatrician representing the AAP-Hawaii Chapter and UH Department of Pediatrics, and the Hawaii CSHCN Title V Director will continue to work together toward achieving the outcomes of CSHCN using a collaborative approach.

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.

a. Last Year's Accomplishments

Preliminary data from the National Immunization Survey (NIS) indicate that 79.1% of children ages 19-35 months have completed the recommended schedule of immunizations in Hawaii, a slight increase over last year, but not statistically significant. The FY02 objective of 77.6% was exceeded. Hawaii compares well to the national rate of 77.9 for the same period.

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.

Given the high percentage of insured children (97.1% in 2002), the rates should be much higher. However, the NIS shows most toddlers who are not completely up-to-date with their immunizations have received most of the required immunization doses.

Ongoing direct services to increase child immunizations include safety-net programs such as immunization clinics supported by Public Health Nursing and the Vaccines for Children Program at the primary care health centers that serve those without health insurance. 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 initiative, funded by the Robert Wood Johnson Foundation, continues to expand its outreach efforts to enroll uninsured children into Med-QUEST.

Population-based services focus on increasing public awareness and include collaborative efforts of the Hawaii Immunization Coalition's Infant Sub-Committee. The Hawaii Immunization Program continues to mail out immunization reminders of to parents of all children under 1 year old who are born in Hawaii.

Ongoing infrastructure building activities focused on strengthening collaboration with public and private partners to improve data collection for assessment and assure accessibility and utilization of immunization services for children and their families. Title V's participation with the Hawaii Immunization Program and the Hawaii Immunization Coalition, which is comprised of public and private stakeholders, are examples of collaborations that collect/review data for assessment and plan population-based initiatives to increase immunization rates.

Most of the activities in FY 2003 were focused on infrastructure building. The DOH convened a statewide meeting of community and medical/health professionals in October 2002 to address the issue of the low immunization rates. Stakeholders from the public and private sectors met to discuss the problem of low infant immunization rates and identify strategies to increase

rates. A work group, the Advisory Committee on Infant Immunization, met to develop a plan based on the conference proceedings.

b. Current Activities

The Hawaii Immunization Program is in the process of analyzing data for a retrospective assessment of all kindergarteners entering school (private and public) in the school year 2002-2003. Staff will examine the school entry health records and immunizations will be assessed retrospectively at ages 24 and 36 months. The results should help delineate patterns of under-immunization by location (using census block groups) and by socio-demographic characteristics.

In FY 2002 a read-to-me immunization coloring book was developed in 5 languages and over 15,000 copies disseminated statewide with other informational materials to various parent groups, primary care health centers, public health nursing offices, preschools, community groups and health fairs. This coloring book is being reprinted with updated information on obtaining medical insurance. Crayons for the coloring books are being supplied by Hawaii Covering Kids.

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.

A Children and Youth Specialist was hired this year by the Title V agency to focus on increasing immunization rates for all ages statewide. Funds were provided by the DOH Immunization Program. The Specialist will work with all purchase of service contractors to increase up-to-date immunization status of children and adults, especially those at increased risk of under-immunization. Contractors include Healthy Start, WIC, Comprehensive Primary Care, Perinatal Support Services, Parenting Support Programs, Family and Community Support Services, and Children with Special Health Needs Branch. Immunization strategies will target special populations including Native Hawaiians, immigrants, homeless, pregnant teens, and the elderly.

c. Plan for the Coming Year

Objectives for 2004-08 for this measure were revised to meet the Healthy People 2010 objective of 80% by the year 2010 using the National Immunization Survey measure for children 19-35 months instead of 2 years of age.

The services described above will continue to be supported by Title V. Covering Kids, a Robert Wood Johnson grant, was recently refunded. 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 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 Maternal and Child Health Branch (MCHB).

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

Advisory Committee on Infant Immunization to explore reasons for the lack of significant improvement in immunization rates. Plans/strategies will be devised based on findings.

Infrastructure building activities will focus on reviewing the results from the provider-based assessment and kindergarten retrospective study. These studies will provide detailed local data to help target interventions and develop more effective programs.

The feasibility of linking vital statistics and insurance data will be considered to develop a cohort profile of infants and their mothers who may not have insurance coverage and whether immunizations were acquired. Data sharing agreements between DOH Vital Statistics and Hawaii's two largest insurance providers (HMSA and Kaiser Permanente) would need to be negotiated.

Other data sets to be explored are the Health Plan Employer Data and Information Set (HEDIS) immunization coverage data for managed care health plans (including Medicaid), FHSD program and contract data, and immunization records for licensed day care facilities.

Despite budgetary constraints and concerns about HIPAA regulations, HIC & HIP will continue to explore the possibility of creating a state immunization registry to improve tracking and identification of children who are out of compliance.

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

a. Last Year's Accomplishments

The 2003 data for this measure is preliminary and indicates a rate of 18.8 live births per 1,000 teenagers aged 15-17. The objective of 23.5 was met. Although the rate increased slightly, the difference is not statistically significant. Relative to national standards, Hawaii compares well. In 2001 (latest available national data) the U.S. birth rate for 15-17 year olds was 24.7 compared to 20.4 for Hawaii.

Title V's efforts to reduce teen pregnancy are population based and infrastructure building services conducted in partnership with state and community agencies. Title V in coordination with the Teen Intervention Program (TIP) at Kapiolani Medical Center for Women and Children surveyed 124 teachers at the Got Health? Teachers Workshop to assess teacher comfort and competency in providing sexual health education. Results indicated further teacher training was needed. Title V took a leadership role in bringing partners together to apply for Temporary Assistance to Needy Families (TANF) funding for teen pregnancy prevention training for teachers. The partners included: Department of Human Services (DHS), Department of Education (DOE), University of Hawaii (UH), College of Education, and teen pregnancy prevention programs.

Education/outreach to youth continued with the DOE Peer Education Program (PEP). The program provides prevention information on teen pregnancy, sexual assault, STD/HIV, and social skills development. Title X funded the Kalihi-Palama Community Health Center's Teen Theatre Group play, *It Can Happen to You*, that candidly portrays the realities of unsafe sexual behavior. Community activities were sponsored by the Hawaii Teen Pregnancy, Prevention and Parenting Council (HTPPPC) statewide during teen pregnancy prevention month. See SPM 05 for health education activities related to the Coordinated School Health Program (CSHP) and surveillance efforts to monitor sexual risk behaviors. See SPM 08 for sexual assault education and intervention activities.

Infrastructure building activities included contracting the Boys and Girls Club of Hawaii to provide Abstinence Education (AEP) for children ages 10 to 12. The program uses a healthy

youth development approach, building self-esteem to make healthy life decisions. District Health Office staff provide infrastructure building services at the county level to increase the availability of health services.

Using Title X funding, the DOH Family Planning Program (FPP) continued to offer confidential family planning services for adolescents. Title X also funds community health educator positions statewide. FPP also targeted male clients for reproductive health education and counseling. FPP sponsored training for providers on the reproductive health needs of men and methods to engage them as consumers of preventive care.

With the help of community advocates, legislation was passed making Emergency Contraception available through pharmacists. Activities to implement the statute were initiated.

b. Current Activities

Population based education efforts continued such as the play, IT Can Happen to You, which is supported by FPP Title X and STD/HIV program funding. "If you think failing a math test is bad -- just think how bad you'd feel failing a pregnancy test" was the slogan used to promote statewide teen prevention activities. It was selected from a HTPPPC sponsored student contest.

Infrastructure building activities included efforts to implement a 2-year DOH/DHS Memorandum of Agreement to support teen pregnancy prevention teacher training that includes: a Summer Institute course for teachers on sexuality education; planning for DOE elementary and secondary school sexuality education implementation; and 3) planning and implementation of the TIP Parent and Child Education (PACE) Puppet Show for Oahu and Hawaii 5th to 6th graders and their parents. Title V provided assistance developing independent evaluation for the TANF trainings. Plans to hire a Teen Pregnancy Coordinator to administer the TANF contracts and oversee statewide teen pregnancy prevention efforts were delayed due to a hiring freeze. These duties were assumed by the Adolescent Wellness Program.

The CSHP began planning activities to implement STD/HIV prevention programs for school-age youth. The objectives are to decrease sexual risk behaviors, strengthen STD/HIV school prevention activities, and increase use of condoms or abstinence especially among specific target groups.

Another federal abstinence education (SPRANS) award was made to Catholic Charities Family Services (CCFS) for a school program targeting 12 to 18 year old youth. Hawaii grantees attended the national Abstinence Education meeting and have begun to collaborate with Title V on program efforts. CCFS is using Hawaii YRBS data and the Hawaii School Health Surveys brochure in evaluation and service provision. The Title V Abstinence Education Program continues to focus on promoting life skills and serving at-risk youth in community-based settings.

Title X continues to provide confidential family planning statewide services for adolescents and encourage partner involvement. FPP trainings focused on preventing and managing sexual coercion and abuse. The training included adolescent counseling approaches and a review of current Hawaii laws pertaining to adolescent services and mandatory reporting requirements. Title X funding supports the Waikiki Health Center's Youth Outreach Program with educational counseling to male clients including incarcerated youth and those attending alternative schools for youth at-risk.

The HTPPPC planned for teen pregnancy month with a slogan/art contest, teenlinehawaii.com website and quiz, radio promotions, and Governor's Proclamation. In a new partnership, health insurance provider, Aloha Care, provided TIP with support for its statewide programs.

Implementation of Emergency Contraception legislation passed in 2003 is pending the adoption of administrative rules, which would allow pharmacists to dispense EC.

c. Plan for the Coming Year

The FY 2003 indicator is still provisional, awaiting the final birth data and the release of 2003 U.S. Census population estimates for the denominator. Preliminary data for 2001 and 2002 was updated.

Hawaii objectives have been set to reduce teen births by .5 percent each year. The related 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 has exceeded the objective. In 2002 (the latest available Hawaii data), there were 29.06 pregnancies per 1,000 females aged 15-17 years.

Ongoing direct, enabling, population based and infrastructure programs described earlier will continue to offer services through FY 2005. This includes neighbor island programs such as Title V funded Malama Kauai offering pregnancy testing, counseling and referral services to teens at the Kauai Community College Wellness Center and DOH District Health Office. Kauai DOH also works with teen Drug Court clients on family planning and STD education.

PEP will be in 15 schools statewide with full-time coordinators supporting educators in providing education on sexual health and risk behaviors. See SPM 05 for continued health education and related CSHP activities. See SPM 08 for public education and intervention services provided by sex assault agencies and the schools.

With some increase in funding, the Title V Abstinence Education Program (AEP) is expanding services for program youth, peer mentors, and parents/significant adults. AEP will also sponsor community events to promote the abstinence only message. Title X is developing training and assessing resources to integrate HIV testing and counseling into family planning visits. Emergency Contraception actions are discussed in SPM 11 and all related efforts would also target the teen population.

TANF teen pregnancy prevention training programs will continue during this timeframe. The TIP PACE Program will be expanded to reach all counties. A Teen Pregnancy Prevention Coordinator will be hired allowing Title V to expand its role in statewide prevention efforts.

Part of the statewide effort to combat drug use in the state includes major support of prevention programs targeted at adolescents during non-school hours. The Governor's administration plans to use TANF resources to begin non-school hour programs at 8 public schools to promote healthy youth development and prevent teen pregnancy. Implementation of the program will begin in FY 2005. Title V is consulting with DHS with program development.

The CSHP will be conducting several HIV/STD prevention activities including gathering qualitative data on school prevention efforts, provide training on HIV/STD prevention for health education teachers, and training for youth to support healthy sexual behavior (abstinence and contraceptive use). Title V is supporting these CSHP sexual health program through teen pregnancy prevention teacher and student training contracts using TANF funding.

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

a. Last Year's Accomplishments

Data is not available for 2002 or 2003. Data for 2002 is expected later this year. The data for this measure comes from the State Department of Health's (DOH) Dental Health Division (DHD).

The major stakeholders (private and public) are acutely aware that Hawaii 's children 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.

The Hawaiian Islands Oral Health Task Force was formed in response to a resolution passed by the State Legislature to develop an integrated plan to improve oral health of Hawaii residents. The "2, 4, 6 Action Plan. The First Steps" was completed in 2003 and includes two priorities: 1) assure that oral health care is available and accessible to all of Hawaii's people, and 2) improve and sustain the oral wellness of all of Hawai'i 's people through wellness education and disease prevention. The plan was presented to the Legislature in March 2003.

Concurrently, neighbor island issues were addressed through a Tri-County Group. The dental coalitions on the neighbor islands have been strong and active advocates for improving children's oral health. This group, representing each of the neighbor island counties, met to develop consensus and formulate plans to address oral health care needs which including a shortage of dental providers treating the underserved, lack of available pedodontists, and a large uninsured population.

Statewide, DHD remains a 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 baby bottle tooth decay prevention and the importance of the dental home and regular care.

Limited dental services are provided on-site for the uninsured population by the community-based safety net providers through state-funded primary care contracts. This allows community health centers to provide more comprehensive care for this population.

With funding from the Maui County Council, Maui Community College developed a Dental Assistance training program, with a training site that offers low cost dental services to the community and provides valuable training experience for students.

The "Fluoride Facts" listserv continues, supported by the Hawaii Dental Association. Different facts about fluoride are distributed periodically.

b. Current Activities

The Hawaiian Islands Oral Health Task Force began meeting to develop steps toward the implementation of the "2, 4, 6 Action Plan. The First Steps." The counties 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 Task Force was successful in securing passage of legislation regarding licensure of dentists. The bill allows issuance of a special community service dental license for U.S. trained dentists or hygienists licensed in other states to practice in Hawaii if they work in an underserved area at a Federally Qualified Health Center or Native Hawaiian Health Center.

The intent is to increase the pool of qualified dental care providers to work in nonprofit health centers that serve the low-income and uninsured.

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.

Maui County has been successful at expanding workforce development programs for dental health professionals and developing community based services. Maui Community College's Dental Assistant Program achieved national accreditation from the American Dental Association in October. The Community Clinic of Maui provides dental care through a Memorandum of Agreement with the Maui Oral Health Initiative. Hui No Ke Ola Pono provides preventive education, assessment and sealants to two elementary school second graders and the Head Start/Early Head Start Programs. The Oral Health Institute of the Pacific offers services for all ages including the disabled and is the educational site for the college dental assistant program.

As part of the Title V five-year needs assessment, a population work group on children and youth was formed including broad representation from across the Title V agency. An evaluation of existing priority needs was conducted in Spring 2003 with key stakeholder input. Oral health was found to be a continuing priority need that has not seen sufficient progress over the past 4 years since the last needs assessment was completed. Broad stakeholder input is currently being compiled to identify priority issues for children and youth. Further input will be sought for problem analysis and strategy design for the priority needs selected.

c. Plan for the Coming Year

Title V will work with the DOH Dental Health Division to acquire updated data for this measure and other child oral health indicators in conjunction with the MCH needs assessment

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. For example, the Community Clinic of Maui has secured a site for a new facility to include dental services. The target date for opening is 2006.

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. A publicly funded dental sealant program for children is ill-advised given huge state budget deficits and the Governor's reluctance to fund any new programs. Moreover, most dental insurance plans in Hawaii cover sealant placement and the number of children with insurance is relatively high. The DHD will be conducting a statewide dental sealant survey next school year as part of its ongoing surveillance on

children's oral health. Travel funding for DHD staff to screen neighbor island children is provided by Title V.

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

a. Last Year's Accomplishments

Due to the small number of child motor vehicle deaths each year, 3 year moving averages were done to compare results. The 2002 indicator is 2.2. The objective was met. Hawaii has exceeded the related Healthy People 2010 objective for this measure; however, the numbers for this measure are so small for the State that the indicator may vary tremendously given 1 or 2 motor vehicle crashes.

Hawaii has been progressive in passing child passenger safety legislation. Currently, laws are in place requiring safety seats for those under 4 years of age and seat belts for children in the back seats of vehicles, requiring attendance at a special class for parents ticketed for not having their child in a safety seat, and prohibiting children under 12 from riding in a truck bed. Efforts continue to pass legislation requiring children between the ages of 4-8 years, and under 80 pounds to be placed in a safety seat or booster seat when riding in an automobile.

The DOH Injury Prevention and Control Program (IPCP) is leading the effort to promote and assure proper use of child car seats and has a coordinator dedicated to these issues. Child safety seat training and check-up sites are being integrated into primary care health centers, medical care facilities, county fire stations, military bases, WIC clinics, and car dealerships throughout the state. Statewide technician and instructor training continues. A 32-hour National Highway Traffic Safety Administration (NHTSA) training course for certification of car seat technicians was held, along with refresher courses.

Title V partnered with the Keiki Injury Prevention Coalition (KIPC), IPCP, and the State Department of Transportation's Safe Communities Initiative to disseminate information and education on injury prevention issues through an extensive network of community organizations.

Enforcement of the State's mandatory seat belt and child safety seat laws through the "Click It or Ticket" campaign continues. During the 2 week program, police conduct a major public awareness campaign on the state's mandatory passenger restraint laws in conjunction with aggressive enforcement, stopping motorists on the move and at special roadblocks.

The Keiki Car Seat Hotline Information and Referral phone service continues to receive calls for reporting car seat violations, information, and as a contact number for various community campaigns.

A permanent safety seat inspection station continues at Kapiolani Medical Center (KMC) for children with special health care needs, and includes assessments and fittings based on referrals, implementation of seat loaner program, and provision of appropriate resources (i.e., health insurance).

KIPC, KMC, and IPCP have worked together to develop a survey for all DOE-contracted bus companies that provide transportation for children with special health needs. The purpose is to gather data on what type of safety measures are provided during transport.

b. Current Activities

Efforts to promote and assure correct use of child car seats continued. IPCP is developing a quality management protocol and manual for all safety seat inspection stations to assure standards of service are maintained. As part of the quality management system, the Traffic Safety Coordinator and CPS Program Coordinator conducted site visits to all inspection stations.

The Child Death Review (CDR) system has identified risk factors in its review of motor vehicle deaths from 1997-2000. These are in order of occurrence: excess speed, reckless driving, drugs, alcohol, and new or unlicensed driver. This information will assist Title V, IPCP and various public and private partners with identifying prevention strategies for these types of child deaths.

Efforts to pass legislation requiring children between the ages of 4-8 years, and under 80 pounds to be placed in a safety seat or booster seat when riding in an automobile failed to pass this legislative session.

IPCP conducted child passenger safety for children with special health needs training for all counties. Flyers were distributed statewide through the State Early Intervention Program and Occupational Therapists based in schools. Due to demand, the 2-hour training was expanded to 8-hour trainings for the Big Island and Maui.

KMC and IPCP submitted an abstract for the Lifesavers 2004 Conference to share the development of the comprehensive services, including children with special health needs.

A visual survey conducted during the annual "Click It or Ticket" car restraint enforcement campaign indicated Hawaii has the highest level of seat belt use in the country. The state became the first to register a 95 percent rate of seat-belt use. Seat belt use was highest on the neighbor islands of Maui (97.2%) and Hawaii (96.1%), which have witnessed several major fatal car accidents during the past year. They were followed by Oahu (94.3%) and Kauai (93.2%). This year's campaign focused on passengers and drivers least likely to buckle up: 18- to 25-year-olds and drivers of pickup trucks.

The heavy media and community promotion around the Click It or Ticket enforcement campaign undoubtedly helped push Hawaii to the 95 percent level, up from 91.8 percent last year and an almost 15 percentage-point increase in seat belt use since 2000. Radio and TV ads blanket the state's media airways during the 2 week campaign and are coupled with a posters/banners fronting many Hawaii venues including fire stations. Police from four counties issued 3,169 seat-belt citations, an increase over last year.

c. Plan for the Coming Year

Ongoing activities for safety car seat use will be expanded as IPCP explores different ways to integrate child safety seat training into existing community service programs for families with young children. They will continue to provide trainings to fit children with special health care needs with safety seats. A network of inspection stations will be developed with the purpose of sharing information, addressing common issues, and securing future funding to expand efforts.

Part of the special needs population services is the lack of a clear policy for wheelchair transportation in Department of Education buses. Plans are to update current policies and procedures and develop and implement appropriate trainings if needed. Simultaneously, wheelchair training for vehicles will be developed for Occupational and Physical Therapists by IPCP.

Efforts to promote compliance with existing child passenger safety laws will continue to be discussed by safety advocates. Title V will continue to support IPCP and the Department of

Transportation (DOT) in their legislative activities to promote passenger safety. IPCP intends to pursue the booster seat requirement in future legislative sessions after addressing the concerns raised by the community.

The Child Death Review system continues to increase awareness of child deaths related to motor vehicle crashes and pedestrian deaths with a multidisciplinary focus on prevention strategies.

Child passenger safety information will continue to be included in the broader spectrum of injury prevention, and educational resources are available to purchase-of-service contract providers, and programs supported by Title V personnel.

The State Department of Transportation anticipates it will continue to receive Federal Transportation funds to conduct the successful Click It or Ticket car restraint enforcement campaign.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

Data from the Newborn Screening program indicate that 80.4% of mothers breastfed their infants at hospital discharge. The objective was not met, however the indicator exceeds the Healthy People 2010 objective of 75%. Data from the 2002 Pregnancy Risk Assessment Monitoring System (PRAMS) reports a higher breastfeeding initiation rate of 89.3%. Although the percentage of mothers who breastfeed their infants at hospital discharge is increasing, the rate quickly declines due to the large numbers of women in Hawaii who return to work.

The Title V program promotes breastfeeding through providing enabling, population based and infrastructure activities. WIC provides comprehensive breastfeeding promotion, education and support to their pregnant and postpartum clients. Services include a breast pump loan program, an incentive program, and a nationally recognized Pumps in the School (PITS) Program. WIC maintains breastfeeding coordinators at the State level and at each local agency and has a policy that requires clinic sites maintain a Breastfeeding Friendly Environment.

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 focusing on Hawaiian families; Malama A Hoopili Pono-the federal Healthy Start Project on the island of Hawaii; Early Head Start and programs under the Native Hawaiian Health Systems.

Hospital delivery centers are also strong proponents of breastfeeding. Kaiser Permanente Hospital holds the prestigious designation of "Baby Friendly" hospital, providing an optimal environment for the promotion, protection and support of breastfeeding. The designation requires a rigorous compliance process and is difficult to achieve. Kapiolani Medical Center is currently working toward 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 Breastfeeding Promotion Council of Hawaii (BPCH) provides leadership for the various hospital programs. The Council has a web site with information on services for breastfeeding mothers. Annually, the Council honors individuals and programs that support breastfeeding.

WIC incorporates information on the New Mothers Breastfeeding Act which 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 places of public accommodation.

Other infrastructure building services that impact this measure include the 2003 Perinatal Health Summit. A breastfeeding work group identified action steps to promote breastfeeding. The State WIC Conference in April 2003 featured an educational module for breastfeeding and prevention of early childhood obesity. This module was provided to WIC local agencies and offered to other agencies.

b. Current Activities

WIC enabling services continues to focus on breastfeeding promotion, education and support to their pregnant and postpartum clients. The WIC breast pump program has 315 electric breast pumps that are loaned to clients on an as-needed basis. Manual pumps are provided to those who do not qualify for an electric pump.

The breastfeeding incentive program provides breastfeeding women certificates, Polaroid pictures, washable nursing pads, infant t-shirt, and nursing drapes at 6 weeks, 6-8 months, and 1-year postpartum, as needed. The nursing drapes were evaluated and found to promote breastfeeding. The Pumps-in-the-Schools Program has now expanded to 13 high schools. The Breastfeeding Friendly Clinic Environment policy prohibits pictures, samples, or logos of formula to be visible in the clinic setting. Hawaii WIC shared these innovative breastfeeding projects at the Western Region Breastfeeding Coordinators Meeting in February 2004.

Title V infrastructure building services include continued support for PRAMS to provide population based data on breastfeeding practices at 2-4 months after birth among Hawaii mothers. PRAMS staff are working in conjunction with the University of Hawaii Clinical Research Center to conduct a follow-up study of PRAMS mothers to determine the prevalence of breastfeeding at 6 and 12 months. The overall goal of the study is to examine ethnic and geographic disparities in breastfeeding initiation, exclusivity, and duration rates, and to identify demographic, behavioral, and environmental factors that enhance the likelihood that a mother will maintain breastfeeding until her infant reaches 6 months of age, and beyond.

The Healthy Mothers, Healthy Babies (HMHB) Coalition surveyed 54 companies to assess their breastfeeding policies and provide information on the current breastfeeding law: 80% had experiences with breastfeeding supports in the workplace, 52% knew about the Act, and 87% wanted more information.

The Hawaii Breastfeeding Challenge took place October 4, 2003, with 174 babies latching-on to 169 mothers exactly at 11:00 am throughout the state. The event increased breastfeeding awareness among the general public, health care providers and media.

WIC continues to increase breastfeeding support and promotion efforts. Special projects include both a neonatal breastfeeding and prenatal outreach campaigns and improvements in the breastfeeding data collection and reporting system. WIC purchased 28 additional electric breast pumps, of which 6 were for the Pumps in the Schools (PITS) project. Evaluation of the electric breast pump program should be completed by July 2004.

WIC developed breastfeeding case studies for training paraprofessional staff at interested local agencies.

c. Plan for the Coming Year

Since the Healthy People 2010 objective for this measure has been met, the measure

objectives assume a moderate increase of 2% annually based on the FY 2000 indicator. Although the percentage of mothers who breastfeed their infants at hospital discharge is increasing, the rate quickly declines due to the large numbers of women in Hawaii who must return to work soon after delivery.

The Title V program staff will continue to provide comprehensive breastfeeding education and support to the high-risk pregnant women, statewide. The program will also continue to support and work with the Breastfeeding Promotion Council to promote breastfeeding friendly work place environments and to continue to assure that breastfeeding women are not discriminated against.

The hospitals continue to improve their breastfeeding promotion practices. The rural Molokai Hospital is now working to receive the prestigious designation of "Baby Friendly" hospital. The additional breastfeeding support provided by these hospitals will increase the number of women who exclusively breastfeed their infants at time of discharge and beyond.

WIC's enabling services to promote breastfeeding will continue, including the expansion of the Pumps in the Schools program. Results from WIC's breastfeeding program evaluations will be used to make program improvements.

WIC will be developing plans for a breastfeeding peer counselor program for FFY 2004-2005. WIC plans to contribute to a second statewide "Breastfeeding Challenge" event on all major islands in October 2004 to build upon the success of last year's event. WIC also plans to pursue a breastfeeding hotline targeted to the Food Stamp and WIC population as well as a Departmental or Division-wide breastfeeding professional to promote breastfeeding across all Departmental programs. Another project would be sharing breastfeeding information from the Newborn Metabolic Screening by source hospitals to the public. Results from the Hawaii Infant Feeding Study should become available.

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

a. Last Year's Accomplishments

The 2003 indicator was 97.8. The objective was nearly met. FY 1999-02 data for this measure was updated.

The Newborn Hearing Screening Program (NHSP) began in 1990 through a law that mandated that the DOH develop methodology to establish a statewide program for screening of infants and children age 0-3 with hearing loss. Amendment of the law in 2001 mandated the screening of all newborns for hearing loss and reporting of screening results to the DOH.

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. Each birthing facility has a hospital newborn hearing screening program. Thirteen of 14 hospitals record hearing screening results in the HI*TRACK data system, and transfer their data to the state NHSP where data are merged. The 14th hospital submits aggregate data to the state NHSP.

Hospitals were bi-annually provided data on their newborn hearing screening performance, including percent of infants receiving initial screens, missed screening, passing initial screens, and returning for rescreens. This is used to identify problems, improve services, and track progress.

The newborn hearing screening brochure was part of the packet sent by the Newborn

Metabolic Screening Program to homebirth families. Newborn hearing screening, audiological assessment and early intervention brochures are available in 9 languages. Brochures are distributed to hospitals and audiologists.

NHSP assisted with follow-up for infants who need rescreening or referrals for audiological assessments. As needed, air transportation from other islands to Oahu for audiological assessments was provided, since the necessary equipment are not available on Neighbor Islands.

In January 2002, IMUA Rehabilitation Program on Maui began screening homebirth children, with screening equipment and supplies provided by NHSP. In 2003, NHSP began outreach to homebirth families statewide through midwives. Hearing screening is available to homebirth families statewide through audiologists and some hospitals.

Written guidelines on audiological followup for infants who failed newborn hearing screening are in place.

Hospital newborn hearing screening program staff record risk factors for late onset hearing loss and send this information with the hearing screen results to the state NHSP, where dates are tracked for follow-up with the physician regarding need for audiological testing.

The State MCH Epidemiologist, with CSHNB, studied demographic characteristics of infants who did not return for follow-up, and concluded that failure to complete the hearing screening follow-up may be related to cultural differences, which has implications for targeting screening efforts and resources. The study was published in Pediatrics, May 2003 Supplement.

Funding from the MCH Bureau for the Hawaii Early Childhood Hearing Detection and Intervention project is supporting the CSHNB/NHSP efforts to improve early hearing detection and inter

b. Current Activities

Newborn screening continues in all birthing facilities. NHSP continues to provide assistance with follow-up for infants who need rescreening or referrals for audiological assessments, and to track follow-up for infants with risk factors for late onset hearing loss.

Draft administrative rules are being revised.

Updated HI*TRACK software, technical assistance and software support were provided to birthing hospitals to facilitate efficient data reporting of newborn hearing screening results to the state NHSP.

NHSP continues to monitor hospital inpatient newborn hearing screening rates and provide technical assistance to address barriers to screening. It also continues to monitor hospital outpatient hearing screening rates for infants not screened prior to discharge, born at home or not passing inpatient screening, in order to address barriers to screening.

In 2003, NHSP began outreach to homebirth families through midwives. Hearing screening is available to homebirth families statewide through audiologists and some hospitals.

Relevant in-service training continues to be provided for hospital newborn hearing screening staff, audiologists, physicians and early intervention providers to improve the quality of newborn hearing screening and audiological follow-up in Hawai'i.

NHSP continues to develop and disseminate public awareness materials to inform parents,

early intervention providers, physicians, and other health care professionals about universal newborn hearing screening and the importance of early intervention services for infants with hearing loss.

With funding from an Early Hearing Detection and Intervention/Tracking, Research and Integration cooperative agreement with Centers for Disease Control and Prevention (CDC), CSHNB is conducting a research study on causes of hearing loss in young children, as part of a multi-state study with Utah, Georgia, and Rhode Island. Purposes are to determine genetic and other causes of hearing loss for children identified through NHSP and to establish a model of genetic services as part of the follow-up of children with hearing loss. The study received DOH University of Hawai'i, and CDC Institutional Review Board (IRB) approvals and is enrolling participants.

c. Plan for the Coming Year

Newborn screening will continue in all birthing facilities. NHSP will continue to provide assistance with follow-up for infants who need rescreening or referrals for audiological assessments, and to track follow-up for infants with risk factors for late onset hearing loss. NHSP will continue improving data collection and tracking procedures.

The lengthy process to establish administrative rules will continue.

A practitioner's manual will be developed.

Newborn hearing screening/follow-up rates will continue to be monitored. Strategies will be developed to help hospitals address screening barriers, such as outdated screening equipment and lack of backup equipment.

Educational sessions/training will continue to be provided for hospital newborn hearing screening staff, audiologists, physicians, early intervention, and other providers.

NHSP will continue to disseminate public awareness materials to inform parents, early intervention providers, and health professionals about early hearing detection and intervention.

CSHNB will continue enrolling participants in the research study on causes of hearing loss in young children. Participants/parents will meet with a genetic counselor and geneticist, and have a physical examination and review of family history and child's medical history. A small blood sample will be tested for connexin 26 and other genes. The study will continue until May 2005.

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

a. Last Year's Accomplishments

The FY 2003 data for this measure shows that 2.9% of children did not have health insurance. The objective of 3.2% was met. This measure is related to Healthy People 2010 Objective 1:1: increase the proportion of persons with health insurance to 100 percent.

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.

There are two issues related to this measure, the first of which is numerator data. The Title V agency collaborates with the Department of Health, Office of Health Status Monitoring which administers the annual population-based Hawaii Health Survey (HHS) to obtain numerator

data. Since this is a residential telephone survey, it has limitations. For example, uninsured individuals are less likely to have a home telephone and are more likely to refuse to participate because of cultural and language barriers. The Title V agency uses the HHS data 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. There are 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.

The second issue related to this measure is improved access to health insurance, which would decrease the numerator. On July 1, 2000, the Department of Human Services initiated two programs aimed at improving access to children. The SCHIP program was implemented as a Medicaid expansion and covers children up to 18 years of age with family incomes up to 200% of the federal poverty level for Hawaii. As of September 30, 2003, 10,699 were enrolled in SCHIP. The second program is a state-funded immigrant children's program targeting legal immigrants, refugees, and those born in the Marshall Islands, Federated States of Micronesia and Palau. It has the same eligibility requirements as SCHIP and as of September 30, 2003, had 2,191 enrollees.

The Title V agency continued to work with stakeholders through HCK, which coordinates activities to improve outreach and enrollment of uninsured children. Electronic Med-QUEST applications increased due to greater number of outreach workers. The Title V agency participated in all these activities and assured that Title V stakeholders were informed of and benefited from these efforts. In addition, all Title V purchase-of-service contracts required that eligible uninsured children be referred for health insurance coverage.

b. Current Activities

The focus of the Title V agency's efforts for the current year, are on infrastructure building services. Collaboration has continued with Hawaii Covering Kids (HCK) to obtain a better estimate of uninsured children in the state. HCK has released a report, Measuring the Number of Children and Youth in Hawaii, based on data in school records. For the 2001-2002 school year, 4.5% of public school children were uninsured. About 1% of those enrolled in private, Catholic and independent schools were uninsured. For children enrolled in preschools and day care centers, approximately 2% were uninsured. There are no resources to obtain these data on a regular basis, which makes the annual Hawaii Health Survey (HHS) the best source of data for this performance measure.

The Title V Director is the principal investigator on two grants to fund the Hawaii Uninsured Project (HUP) that was established to address the problem of uninsured individuals in Hawaii. The grants were submitted by the Title V agency on behalf of a consortium of state, business, labor, health and community leaders dedicated to provide universal health insurance coverage to all residents in the state. Grant funds are contracted to the University of Hawaii and non-profit agencies for implementation. A Health Resources and Services Administration (HRSA) State Planning Grant to evaluate and identify best strategies to lower the state's uninsured rate will end this summer. A three-year demonstration grant for \$3.2 million awarded by the Robert Wood Johnson Foundation is in its second year. Efforts continue to explore solutions with stakeholders and conduct economic modeling of the various options. Recommendations will be made to improve the reliability of the estimates of uninsured children. This information will be useful as the Title V agency is in the midst of its 5-year needs assessment. HUP has formed a committee of advocates, health care and health coverage experts, and state officials to develop and analyze potential solutions for increasing coverage for children, with an emphasis on those in families with incomes between 200% and 300% of the federal poverty level.

The Title V agency continues to work in partnership with HCK which coordinates several activities to assure that all eligible uninsured children obtain health insurance coverage. In January 2004, HCK efforts resulted in a new simplified Med-QUEST application form for children and pregnant women. HCK local projects in Kahuku on Oahu and on the island of Kauai continue to develop innovative outreach and enrollment strategies and models that can be replicated by other communities. All Title V purchase-of-service contracts continue to require appropriate referrals for uninsured children who are eligible for health insurance coverage.

c. Plan for the Coming Year

Infrastructure building services will continue through FY 2005. In partnership with the Hawaii Covering Kids (HCK) and the Hawaii Uninsured Project (HUP), 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 Hawaii Health Survey data. The objectives are currently projected with the FY 2000 indicator as the base, to result in zero in 2010.

The HUP will continue to work on improving estimates of uninsured children. Activities are currently focused on comparing data from the Current Population Survey of the U.S. Census and the Hawaii Health Survey. Strategies for increasing coverage of children will be developed, with an emphasis on those in families with incomes between 200% and 300% of the federal poverty level.

The Title V agency will continue to work in partnership with HCK to expand outreach and enrollment of uninsured children. The plan for next year includes discussions with the Medicaid agency to consider self-declaration of income and assets. Current documentation requirements for verification of pay stubs and other income are a problem for some applicants, resulting in applications being denied. All Title V purchase-of-service contracts will continue to require that eligible uninsured children be referred for appropriate health insurance coverage.

The Title V agency initiated its 5-year needs assessment in 2003. Accurate data on uninsured children will be important as this indicator provides some assessment of access to health services for children.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

a. Last Year's Accomplishments

The FY 2003 data show that 43.9% of potentially Medicaid-eligible children received a service paid by the Medicaid program. The objective of 77.2% was not met. The objectives for FY 2002 through 2010 were revised in the 2003 Title V application because improved reporting by the health plans contracted by the Medicaid agency had contributed to steady increases in this measure. Performance objectives were recalculated to result in an objective of 96% in 2010. However, fiscal year 2003 data does not appear accurate, when compared to the fiscal year 2002 indicator of 79.2. The reasons for this discrepancy will be discussed with the Medicaid agency so that more accurate data can be obtained. This measure is related to the Healthy People 2010 Objective 1-4b: Increase the proportion of children and youth aged 17 years and under who have a specific source of ongoing care to 96%.

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 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 2003 Hawaii Health Survey.

This performance measure 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 NPM #14. The major activities under NPM #14 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 has collaborated with the EPSDT program and the health plans contracted by Med-QUEST to promote EPSDT. This information has been given to providers of care and Medicaid clients. 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 transportation, translation and case management services.

b. Current Activities

The focus of the Title V agency's efforts for the current year, are on infrastructure building services. The same data sources will be used for this measure. However, because of the discrepancy with the fiscal year 2003 data reported in the previous section, meetings are planned with the Medicaid agency for clarification. In November 2002, the Arizona Health Care Cost Containment System (AHCCCS), the Arizona Medicaid agency, established a management information system for Hawaii Med-QUEST. In a unique state-to-state partnership, the Arizona Prepaid Medical Management Information System (PMMIS) was modified to handle records from the Hawaii Medicaid program. Hawaii is contracting with Arizona to house the system and provide needed reporting. Reporting delays have been experienced since the transition to the new system. However, the Hawaii PMMIS is expected to improve the quality of information produced for the Med-QUEST program.

Last year's activities continue into the current year. This year, a subcommittee of the Medicaid agency's EPSDT Advisory Committee was formed to improve utilization of EPSDT services. Initial members are the EPSDT coordinators of the health plans contracted by Med-QUEST and Title V agency staff. Meetings have focused on addressing barriers to utilization as identified by subcommittee members.

c. Plan for the Coming Year

Infrastructure building services will continue through FY 2005. The same data sources will be used for this measure. The Title V agency will collaborate with Med-QUEST to obtain more accurate data and compare the data with previous years' reports. Data will be updated in next year's report.

Last year's activities will continue into FY 2005. The new subcommittee to improve EPSDT utilization will develop and implement strategies with an emphasis on policy and systems change. Participants may be expanded to include community health centers, public health nurses and other public and private agencies.

The 5-year Title V needs assessment was initiated in fiscal year 2003 and will continue into fiscal year 2005. As the Hawaii PMMIS improves the quality of information and reports for the Med-QUEST program, the Title V program will have additional data for assessing the utilization

of health services and health outcomes for the EPSDT population.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

The indicator for 2003 is 1.4%. The objective of 0.9% was not met. Hawaii is closer to reaching the Healthy People 2010 objective of 0.9%.

Infrastructure building services that impact this measure include contracting perinatal support services (PSS) for high-risk women statewide for prenatal care, risk assessment, case management, referral and other supports. Services are also contracted for the Baby Substance Abuse Free Environment (SAFE) program to provide outreach, early identification, and pretreatment services for substance using pregnant women.

Title V funds the Kauai Malama Project through the Kauai District Health Office (DHO) to provide case management to high-risk pregnant women. Kauai.

Through the federal Healthy Start initiative the Big Island DHO receives funding to implement the Malama A Hoopili Pono Program to reduce health disparities for pregnant women and infants. The program targets Hawaiian, Filipino and Pacific Island women for culturally appropriate support, case management, and health services.

Smoking during pregnancy has been linked to very low birth weights. Title V programs partnered with agency and community programs to target smoking cessation messages to pregnant women and provide training for perinatal providers. Kauai Malama and PSS programs trained staff on smoking cessation using "Brief Intervention" strategies with funding by the DOH Tobacco Prevention Program. The Maui Economic Opportunity administered funding from the American Legacy Foundation for smoking cessation intervention/counseling to Hispanic families. The Maui DHO implements the cessation program at the WIC clinic sites through 2005.

New research and studies on periodontal disease and premature labor prompted several PSS providers to increase referrals for dental care to pregnant women. The Maui Oral Health Center received a grant from the March of Dimes to provide dental care to uninsured pregnant women. Pregnant woman without dental insurance receives the phone number to call for free dental services from the Center. A dental clinic was opened in December 2003 at the Kauai Community Health Center-Waimea making low-cost dental care available.

Title V funding to MothersCare enables the program to purchase toothbrush/toothpaste for the PSS programs to distribute to pregnant women with information on the importance of good oral health. MothersCare also promotes the importance of prenatal care and maintains a statewide informational and referral phone line for perinatal health.

The Healthy Mothers Healthy Babies provides advocacy for pregnant women to assure access to prenatal care and through policy development. The Hawaii Perinatal Consortium (HPC) is exploring the issues of prematurity and low birth-weight through a workgroup established at the annual Perinatal Summit.

The Title V Pregnancy Risk Assessment Monitoring System (PRAMS) collected information on maternal behaviors. Data for 2002 was received from the CDC and is currently being analyzed.

b. Current Activities

The Title V program continues focus on infrastructure building through monitoring contracts for perinatal support services to high-risk pregnant women statewide. Title V continues the Malama program on Hawaii island. Through culturally appropriate interventions and the use of outreach workers, community awareness and involvement has been increased to improve birth outcomes. Other community based services continue including the smoking cessation counseling at Maui WIC Clinic sites targeted at the growing Hispanic population.

The Kauai Malama continues to offer smoking cessation and intervention counseling, case management and perinatal health education for high-risk pregnant women. The Kauai Community Health Center opened a dental clinic in 2004 to offer low cost dental care which will decrease the incidence of periodontal disease that can prompt premature labor.

In 2004 the Kauai Malama Project signed an agreement with the Drug Court to have pregnant women with a substance abuse problem referred to the program for support, counseling and referral for treatment. The Kauai DHO chairs the Substance Abusing Pregnant Woman task force that looks at ways to encourage these women into early prenatal care and support services.

The March of Dimes (MOD) continues to partner with Title V programs to reduce infant mortality and morbidity. The MOD held a Prematurity Summit in February that was video broadcast to the neighbor islands. MOD grants continue to support community based services including free dental care to pregnant women on Maui. On Kauai, a MOD grant is being used to provide incentives to encourage pregnant women continue prenatal care.

Title V is working to assure access to dental care for pregnant women. Periodontal diseases represent a previously unrecognized and clinically significant risk factor for preterm low birth-weight. Training of perinatal providers will include education and counseling of pregnant women with poor oral health habits.

Title V is keenly aware that the scientific evidence indicates that maternal health prior to conception is one of the most significant factors in assuring healthy birth outcomes. The HPC, Perinatal Advocacy Network (PAN), and other perinatal stakeholders continue to seek evidence based best practices to address the problem of premature labor and low birth-weight babies.

Quarterly meetings for the HPC, PAN, and PSS providers continue to foster communication, networking and consensus building among perinatal stakeholders to further decrease infant mortality and morbidity. The HPC Data Committee finalized the new birth certificate format and hospital staff was trained to properly complete and submit the birth certificates.

The annual Perinatal Summit scheduled for July will feature researchers Drs. Milton Kotelchuk and Greg Alexander discussing the latest research on prematurity and low birth. The Summit will also be used to collect stakeholder input to identify critical health needs for the perinatal population.

c. Plan for the Coming Year

Objectives were set to the Healthy People 2010 target of 0.9% since the difference between the current indicator and target is minimal. Small numbers make it difficult to project real and sustained changes. Provisional 2003 data will be updated.

Ongoing activities described in previous years will continue. Anticipated State budget cuts may effect funding of contracted services supported by State general funding. The Hawaii Perinatal

Consortium will implement recommendations generated from panel discussions/breakout groups at the 2004 Perinatal Summit.

Title V staff will continue to work with state/community partners to complete the 5 year needs assessment and plan. Data on low birth weight and prematurity will be included in the final needs assessment report.

Title V in conjunction with the March of Dimes will continue to focus on infant mortality and morbidity and the prevention of premature labor and low birth-weight babies.

Further training of perinatal providers will include referral resources available in the community and education focusing on preventative oral health care. Smoking cessation activities will continue. As funding becomes available, more Title V program staff will be trained in the "Brief Intervention" strategy so more smoking cessation counselors become available to pregnant women.

The HPC, PAN, and other perinatal stakeholders will continue to advocate for improved systems of care for perinatal health including dental care for pregnant women, substance abuse treatment services, and early access to prenatal care.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

a. Last Year's Accomplishments

Due to the small number of teen suicides each year, 3 year moving averages were done to compare results. The 2002 indicator is 9.0. The objective for FY 2003 of 6.0 was not met.

Title V's program activities to reduce adolescent suicide consider recommendations found in the National Strategy for Suicide Prevention (NSSP). Strategies to prevent adolescent suicide include increasing awareness about the problem; recognizing the link to mental health and substance abuse disorders; improving health care access; and surveillance for those at risk. See SPM 5 narrative on teen smoking for efforts to reduce teen substance use and SPM 8 for physical fighting in the State. See narratives for PM 13 and PM 14 on State efforts to increase accessibility to health care for children.

Hawaii has made a major investment in infrastructure building services by supporting surveillance instruments on adolescent behavior including the Youth Risk Behavioral Survey (YRBS) for High School and Middle School students in the public schools. The survey includes questions on suicidal thoughts and behavior. Data from the 2003 High School YRBS are provided in the attached table. Despite efforts by the interagency Adolescent Survey Committee to improve data collection for all four school health surveys, an adequate sample was not drawn to produce weighted data for the 2003 YRBS (see discussion in SPM 05 and SPM 08).

The Hawaii Child Death Review Council (CDRC) received training to improve data collection and case review procedures for all child deaths including instances involving suicide. Information from the case reviews is used by agency council members to identify potential program and policy changes to prevent child death. The Child Death Review Coordinator participated in the national Suicide Prevention Advisory Advocacy Network Conference where states were encouraged to develop strategic plans for suicide prevention.

Population based programs incorporate best practices in healthy youth development as outlined in the State Adolescent Wellness Plan, *Laulima in Action*. Many of these programs are

school based. The Department of Education (DOE) Peer Education Program (PEP) trained 868 peer mentors at 26 schools statewide, reaching 41,216 youth through one-to-one contacts addressing topics including injury, violence, and suicide.

The Healthy Hawaii Initiative (HHI) funded a Summer Institute for teacher training focused on the new DOE health standards. Curriculum included methods to build youth resiliency, teaching strategies for at-risk youth, mental and emotional health promotion focused on loss and grief. A 3-Year Coordinated School Health Infrastructure Grant from the Centers for Disease Control began efforts to build agency coordination and capacity to promote health among students. Grant partners are DOE, DOH and the University of Hawaii.

b. Current Activities

Population based services provided through the DOE PEP continued as an important student suicide prevention effort. The DOE modified the PEP program this year to strengthen school support for the program. Principals were asked to apply to be a PEP site to receive funding for a full-time Coordinator. Schools demonstrate their commitment to sustaining the PEP program by agreeing to fund 50% of the Coordinator's time in Year 2 of the 3-year pilot project. Fifteen schools were selected to be PEP sites (2 intermediate and 13 high school).

By September 2004, all sites will be operational and include 10 Oahu schools (2 which will be Intermediate) and one school in each DOE District and neighbor island (Maui, Molokai, and Hawaii). There will also be 4 high schools independently offering PEP as an elective class through part-time Coordinators who teach other classes. With the savings realized in Year 3, PEP will be expanded to another 7.5 schools.

The Coordinated School Health Infrastructure Grant is providing some resources for YRBS high school survey and data analysis with the goal of producing weighted data. The Hawaii High School Health Survey highlights publication was developed and includes YRBS High and Middle school suicide behavioral risk measures. Thousands of copies were distributed to parents and school personnel.

Other infrastructure building activities include Title V's participation in the HRSA CompCare technical assistance project to improve the child health system of care. The Hawaii Comp Care Team is working on the final report of telephone survey findings of the preventive health service system for children ages 4-14.

The CDRC and its teams are preparing a CDR report including suicide information from 1997 to 2000. Findings will be shared with stakeholders to increase awareness of this issue and discussion of next steps. This report is projected to be released during fall 2004.

As part of the Title V five-year needs assessment, a population work group on children and youth was formed including broad representation from across the Title V agency. An evaluation of existing priority needs was conducted in Spring 2003 with key stakeholder input. The issue of violence, including teen suicide, was found to be a continuing priority need for this population. Broad stakeholder input is currently being compiled to identify priority issues for children and youth. Further input will be sought for problem analysis and strategy design for the priority needs selected.

c. Plan for the Coming Year

Objectives for this measure are set to show an incremental decline every 2 years of 1%.

PEP will continue to offer education to youth in areas of injury/violence and sex assault. See SPM 08 for additional information on sex assault and the Building Partners for Youth Project

which created a CD with resources/information on promoting partnerships for healthy youth development and non-school hour programming.

HHI Summer Institute funded courses will continue to include "Building Resiliency In Youth" and "Loss and Grief Approaches for Educators: Mental and Emotional Health Promotion" for K-12 teachers, counselors and administrators in public and private schools.

The Comprehensive School Health Program Infrastructure Grant has developed a Blueprint for Action to promote health issues at the school level, including drug use and abuse and other mental health concerns. Four School Complexes (made up of a high school and its feeder middle and elementary schools) have been selected as pilot sites. Each complex has identified a team of school and community partners to work on the project. All team members will receive in-depth training from The School Health Leadership Institute to assist each complex to build organizational capacity to promote school health programs. See SPM 05 for additional information on this implementation plan.

The CDR Coordinator is involved in meetings to develop the suicide component of the State Injury Prevention Plan through the Injury Prevention and Control Program (IPCP). MCH Branch and IPCP have formed a workgroup to assess how the two DOH programs can coordinate injury prevention efforts which include the topic of suicide.

The Title V agency will complete the MCH needs assessment. Data on teen suicide and other youth violence data will be included in a final report.

Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

a. Last Year's Accomplishments

Provisional data for 2003 indicate 86.9% of very low birth weight infants were delivered at facilities for high-risk deliveries and neonates. This exceeds the target of 86.4% set for 2003. Hawaii is close to achieving the Healthy People 2010 objective of 90%.

Hawaii has no formal designation of 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. They do 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. For this measure, Kaiser is considered Level III.

Tertiary care centers are located only on the island of Oahu. There is limited access to specialty obstetric care on the neighbor islands and in rural Oahu for high-risk pregnant women. On Lanai, pregnant women receive care from family practice physicians. An OB specialist flies in once a month. All deliveries (except precipitous labor emergencies) on Lanai occur on the islands of Oahu or Maui. On Molokai, certified nurse midwives provide perinatal care to pregnant women. Low-risk deliveries use a midwife for delivery. All other deliveries are flown to Oahu.

Title V activities focus on infrastructure building services. To identify high-risk pregnancies, the Title V program contracts perinatal support services for high-risk women statewide. The Malama program on the island of Hawaii, a federal Healthy Start initiative, also works with the island's high-risk populations to identify women at risk for problem deliveries and neonates and assure access to health care services.

The Title V program is also working toward assuring access to the tertiary birthing center on Oahu from the neighbor islands through the air ambulance system. Legislation to appropriate funds to expand the State's air ambulance helicopter system to rural areas in Maui County was appropriated by the 2003 Legislature.

The Hawaii Perinatal Consortium Data Committee continued to work with DOH Office of Health Status Monitoring (OHSM) to improve the quality of birth certificate data. Although all state hospitals now transmit birth data electronically, OHSM hopes to convert all hospitals to the same web-based program. Title V funded the development of an edit check program, sponsored a Birth Certificate workshop for hospital staff, and is developing a procedure manual for birth records. FHSD and OHSM have been meeting with the individual hospitals to discuss strategies to improve data quality.

The High Cost of Birth study is linking additional maternal/infant data to create a more complete picture of birth outcomes. The 3rd year of grant funding for the study was approved by HMSA Foundation to support ongoing investigation.

b. Current Activities

The Title V program is continuing to fund purchase-of-service contracts to assure perinatal support services are available to high-risk pregnant women statewide. The Malama A Hoopili Pono program on the island of Hawaii, a federal Healthy Start initiative, continues to identify women at risk for problem deliveries and neonates and provide direct health care and enabling services.

The Kauai Malama Project, a community based perinatal services program, received Title V funding to continue case management, outreach, and enabling services for at-risk women. The funding is administered through the Kauai Rural Health Association with the Kauai District Health Office (DHO) serving as advisors and consultants. The Kauai Malama Project assists high risk pregnant women to access perinatal health resources and provides case management for women at risk for problematic deliveries and neonates.

The study on high cost births in Hawaii will continue. Funding for a third year from the HMSA Foundation will enable Healthy Mothers/Healthy Babies Coalition, in partnership with the Hawaii Health Information Corporation, to implement a change in the medical records system that will automatically link mother and infant records so that manual linkage will not be required in the future.

To improve access to tertiary care centers located on Oahu from the neighbor islands, the Governor released state funds appropriated in 2003 to begin Maui's helicopter medevac service on July 1. The air ambulance service is seen as vital for Maui County because it includes three islands and has only one major critical care unit at Maui Memorial Medical Center. Hawaii County receives matching state funds for its air ambulance service and Oahu's air service is provided by the Army. Kauai has three hospitals and some military helicopter support and will be the only county without the air ambulance. The release of state funding for Maui air service was delayed because of potential state liability over the lack of such service on Kauai. However, legislation was passed this session which limits the state's liability from lawsuits over this issue.

Additional funding was appropriated by the Legislature to expand ambulance services to rural Oahu and provide training for paramedics. Governor's approval is pending.

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 2003 will be updated.

Infrastructure building services will continue through contracts to agencies and programs throughout the state. The Title V program will continue to fund purchase-of-service contracts to assure perinatal support services are available to high-risk pregnant women statewide. The Malama A Hoopili Pono program on the island of Hawaii will continue to focus on identifying cultural issues and practices that relate to pregnancy and provide health services to high-risk pregnant women.

The Data Committee for the Hawaii Perinatal Consortium (HPC) will continue activities to improve the quality of the perinatal data collection system to assure timely and accurate data dissemination.

FHSD will analyze birth records of infants born outside of tertiary care centers to determine why problem births occur outside of the centers. The investigation can lead to recommendations about system changes that will help bring high-risk pregnant women to the tertiary care centers on a timely basis for urgent deliveries. The information will be included in the completed Title V MCH needs assessment report due in July 2005.

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

a. Last Year's Accomplishments

Provisional data for 2003 indicates 80.4% of pregnant women received first trimester prenatal care. The objective of 85.4% was not met. Hawaii rates have been stable over the years and comparable to national rates. In 2001 (latest U.S. data) the Hawaii rate was 82.0% versus 83.4% for the U.S.

The increase in immigrants from the Marshall Islands, Philippines, and Southeast Asia may partially explain the lack of progress (although their numbers are relatively small). State-contracted perinatal providers, report many of these women do not to have health insurance and will delay prenatal care.

The Title V program assured access to prenatal care by funding and monitoring contracts for Perinatal Support Services to high-risk women at 10 sites statewide. Providers promote early entry into prenatal care to identify medical and psychosocial risks. Title X Family Planning programs work in conjunction with Title V programs to provide referrals to prenatal care for women who have positive pregnancy tests.

The Title V program, in collaboration with the Hawaii District Health Office (DHO), continued the Malama A Hoopili Pono, a federal Healthy Start Initiative, that targets health care services to high-risk pregnant women to decrease infant mortality and morbidity on Hawaii island.

Kauai Rural Health Association and Kauai DHO received Title V funding for the Malama Kauai Project to conduct outreach to high-risk pregnant women and assure early entrance into prenatal care. Title V also funded MothersCare for Tomorrow's Children to provide population based services to promote prenatal care through incentive programs, media advertising, and a statewide information line for pregnant women to secure medical care and insurance.

Quarterly meetings of state perinatal providers and advocates are convened by Healthy Mothers Healthy Babies and Title V staff to address perinatal health issues including promoting prenatal care and access.

Community advocates introduced legislation in 2003 to reinstate a Medicaid presumptive eligibility policy for pregnant women. The legislation was deferred. Instead, agreement was reached between the Department of Human Services (the state Medicaid agency), the Department of Health and the advocates to identify administrative remedies for the delays.

Title V continued to collect data for the Pregnancy Risk Assessment Monitoring System (PRAMS), a population based survey of mothers at 2-4 months after the child's birth. The data provides information on maternal behaviors that is useful for perinatal health planning and policy development.

A State Perinatal Summit identified priority perinatal health issues. Action plans were created to guide efforts for improving perinatal outcomes. Stakeholders formed committees to address access to care, prematurity/low birth-weight, substance abuse, breastfeeding, post-partum depression, and domestic violence.

b. Current Activities

The Title V program continues to assure access to care by contracting for perinatal support services to high-risk pregnant women statewide. The Malama program on the island of Hawaii, a federal Healthy Start initiative grant, continues efforts to identify cultural issues and practices to improve pregnancy outcomes for high-risk women including early entry into prenatal care.

Similarly, community programs like Kauai Malama Project provides perinatal support services to the high-risk pregnant women. Title X Family Planning programs continue to work in conjunction with Title V funded programs to provide referrals to prenatal care for women who have positive pregnancy tests.

Title V also continues to fund MothersCare for Tomorrow's Children to supply incentives for pregnant women to enter prenatal care early, to manage the pregnancy information hotline, and other programs that promote perinatal health.

The quarterly meetings of the State Perinatal Providers and Perinatal Advocates Network continue, coordinated by HMHB and Title V staff. Speakers on perinatal health topics were also incorporated at these meetings to provide education and current research findings on the effects of substance abuse during pregnancy, genetics, and sexually transmitted diseases.

The Department of Human Services (DHS) announced in February a new Medicaid policy to process applications by pregnant women within five days. Applicants have experienced delays as long as two months or more. To address concerns among perinatal advocates, DHS in collaboration with the Department of Health (DOH) agreed the new policy would be monitored for efficacy. DHS does not support presumptive eligibility because it would be more costly to the State.

In July the Governor signed legislation authorizing the DHS to provide state-funded medical assistance for pregnant legal immigrants with low incomes.

The Title V program continues to collect data from the Pregnancy Risk Assessment Monitoring System (PRAMS) to build infrastructure related to data. Title V is distributing analyzed data from 2000-01 to perinatal service providers, policymakers and the general public. Analysis has been completed on data for low birth weight, breastfeeding, and substance use, and is being presented to the perinatal community.

The Hawaii Perinatal Consortium is continuing its efforts to strengthen the infrastructure of the state perinatal service system and will hold the 2nd annual Perinatal Summit in July 2004,

featuring Dr. Milton Kotelchuck as the keynote speaker. This Perinatal Summit will build from the previous summit and focus on prematurity/low birth-weight, perinatal depression, post-traumatic stress disorder, and substance use during pregnancy.

c. Plan for the Coming Year

Objectives for this measure were set to achieve the Healthy People 2010 objective of 90% in 2010. Title V will use the 5-year needs assessment process to review PRAMS and vital statistics data to identify specific barriers to prenatal care and develop a profile of high risk women that do not access early prenatal care.

The Title V program will continue to fund and monitor purchase-of-service contracts to provide perinatal support service to high-risk pregnant women statewide and assuring access to care for this vulnerable population. The Malama A Hoopili Pono program on the island of Hawai'i, a federal Healthy Start initiative, will continue to provide direct health care and enabling services for high risk women to identify cultural issues and practices that relate to pregnancy. Similarly, community program like Kauai Malama Project provides peirnatal support services to the high-risk pregnant women.

Title X Family Planning programs will continue to work in conjunction with Title V funded programs to provider referrals to prenatal care for women who have positive pregnancy tests. Title V will continue to fund MothersCare for Tomorrow's Children to support population based programs that promote the importance of prenatal care.

The Title V program will continue to support the Healthy Mothers Healthy Babies Coalition to convene quarterly meetings of the perinatal providers and perinatal advocacy network to identify issues of concern and expand educational opportunities for the network. Advocates will closely monitor the processing time for pregnant women applying for Medicaid coverage. If the new 5-day processing policy does not result in reduced delays, community advocates will likely introduce legislation to reinstate the Medicaid policy of presumptive eligibility in 2005.

The Title V program will continue to collect data form the Pregnancy Risk Assessment Monitoring System (PRAMS) and will distribute the analyzed data to perinatal service providers, policy makers and the general public. Revisions to the 2005 questionnaire will be made, introducing questions relating to HIV, post-partum depression, breastfeeding and general health.

Title V will refine the data forms used by PSS providers and improve the data collection system by developing new software for providers to input data. Revising the data collection system will result in higher data quality, this will enable Title V staff to effectively evaluate the perinatal program services.

The Hawaii Perinatal Consortium will continue its efforts to strengthen the state perinatal service system. The Perinatal Summit work groups will meet throughout the year to address perinatal priorities such as access to care. Planning for the 3rd Perinatal Summit will be conducted and the annual conference held.

The Title V agency will complete the MCH needs assessment. Data on the access to prenatal care will be included in a final report.

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Expand state mandated screening from 7 to 31 disorders.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Contract for central laboratory testing.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Contract for transport of specimens to central laboratory.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Support genetics/metabolic clinics for children with metabolic disorders.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Follow-up/track infants with abnormal and unsatisfactory screening results or not screened.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Follow-up with medical home to ensure timely treatment for infant with metabolic disorder.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Update/distribute newborn metabolic screening brochure to birthing facilities and providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Update/distribute newborn screening practitioner's manual (guidelines) to primary care providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9. Conduct educational sessions for practitioners, nurses, laboratories, and birthing facilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
10. Quality assurance with monthly screening practice profiles sent to birthing facilities/submitters.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) 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)				
1. Involve family members in councils, task forces, and advisory and planning committees.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Involve family members in presenting a family viewpoint at workshops and training sessions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Compensate family members for participation, e.g., stipend, transportation costs, and child care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Support opportunities for family members to attend local/national conferences and workshops.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Include family members as panel members in interviews for staff positions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Involve family members in developing and reviewing parent education materials.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Involve/support families in advocating for policy change (e.g., testify at legislative hearing).	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

8. Analyze/disseminate Hawaii data on family partnership from the National Survey of CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Use Hawaii data on family partnership in needs assessment and planning toward improving outcomes for CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) 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)				
1. Incorporate the medical home into direct/enabling services with families.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Incorporate the medical home concept in planning/structure of programs and services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Identify/address issues and barriers to service delivery, to support care by medical home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Education/training regarding medical home approach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Participation in planning/activities of Medical Home Implementation Project	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Analyze/disseminate Hawaii data on medical home from the National Survey of CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Use Hawaii data on medical home in needs assessment and planning toward improving outcomes for CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
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. (CSHCN Survey)				
1. Provide information and assist uninsured CSHCN/families in obtaining health insurance.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Promote access to health insurance for families of uninsured children in child care settings.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide information/assist families in accessing other public resources, e.g., SSI, Medicaid waivers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide and/or contract medical and other health services as a safety net for uninsured and underinsured CSHCN.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Identify/address issues/barriers of CSHCN in accessing insurance/services to meet needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Support legislative efforts to provide/mandate services when insurance does not meet family needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Obtain Hawaii data on underinsured CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Analyze/disseminate Hawaii data on health insurance from the National	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Survey of CSHCN.				
9. Use Hawaii data on health insurance in planning/improving outcomes for CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) 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)				
1. Provide medical specialty and other services as a safety net for CSHCN who have no other resources, and to increase access to services.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Improve coordination of health, education, social, and other services for CSHCN.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Advocate/work toward increasing resources to meet increased need or gaps in availability of services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide education/training on services/resources for CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Establish and maintain collaborative partnerships to address improving outcomes for CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Analyze and disseminate Hawaii data from National Survey of CSHCN regarding organization of services, including access to care and barriers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Use Hawaii data on organization of services in needs assessment and planning toward improving outcomes for CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Provide transition planning and support as children/youth with special health care exit program services to other settings/services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide info, assist children/youth/families in accessing public resources, e.g. SSI or DD/MR waiver.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide outreach to SSI/medically eligible children under 16 referred by Disability Determination Branch.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide training/information on transition planning and support when children exit from Part C (IDEA) services to other settings.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provide training/information on strategies for successful transition, including work, independence, and adult health care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Obtain information on other transition services/projects in community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Analyze/disseminate Hawaii data on transition from the National Survey of CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Use Hawaii data on transition in planning/improving outcomes for	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

CSHCN				
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Provides immunizations for the under- and uninsured children at statewide clinics.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Contracts to provide immunizations to the uninsured children at community health centers.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provides referral and follow-up on immunizations for low income mothers through MCH programs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provides education and outreach to at risk families of young children at community health centers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Sends out immunization reminder notices to parents of children born in Hawaii under 1 year old.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Provides education and outreach to promote immunization awareness	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Supports collaboration among agencies/programs to improve child immunization rates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Develops policy to support increased immunizations among children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Monitors immunization rates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Provides teen pregnancy prevention education to students and communities.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Coordinates community planning efforts to prevent teen pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Supports inter-agency collaboration and networking to prevent teen pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Plans and administers Temporary Assistance to Needy Families funds for teen pregnancy prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Contracts for Abstinence Only Education Program to selected at-risk communities.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Contracts for family planning educational outreach and clinical services.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Improve inter-agency collaboration to build infrastructure needed to support and sustain the Coordinated School Health Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Improves surveillance systems through inter-agency planning efforts to administer 4 school health surveys that collect student health data used for program planning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

9. Expand teen pregnancy prevention efforts to include non-school hour programs based on healthy youth development strategies.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Provides oral screenings, education and provides follow-up in serious cases in elementary schools.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Administers fluoride rinse programs in public schools.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Collects, analyzes and publishes oral health data on children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provides dental services to low-income and uninsured through community health centers.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Provides oral health education to WIC low income pregnant women and young mothers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Maintains Fluoride Facts listserve to provide reliable information on community water fluoridation.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Mobilize statewide task force to implement Oral Health Action Plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Supports Neighbor Island oral health community coalitions to plan and conduct activities/programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Use Hawaii data on children's oral health to complete needs assessment and an action plan in collaboration with state/community partners.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Conducts surveillance on child injury and death to use for policy development and planning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Conducts educational outreach on child passenger and pedestrian safety.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Enforces seat belt and child safety laws through 'Click It or Ticket' program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Conducts safety seat checks through an extensive network of permanent sites and at special events.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Conducts training for safety seat inspection/installation technicians and instructors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Conducts safety seat inspection and loaner program for children with special needs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Identifies prevention strategies by reviewing information surrounding child deaths.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Assures quality of car seat inspections stations by developing a quality management protocols.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Supports state and community injury prevention coalitions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Contracts to provide breastfeeding education and support to high-risk pregnant women statewide.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provides breastfeeding promotion, education and support to WIC pregnant and postpartum clients.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Hospitals employ lactation consultants or nurse midwives to provide breastfeeding support to moms.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provides information on breastfeeding to the public and professionals.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Supports networking among programs and advocating for policies that support breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Implements action plans related to breastfeeding promotion identified at the State Perinatal Summit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Collects breastfeeding data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Conducts research to determine breastfeeding prevalence at 6 and 12 months after birth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Plans major statewide breastfeeding promotional events and campaigns.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Continue newborn hearing screening at all birthing hospitals in Hawai'i.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Assist with follow-up for rescreening, audiological assessment, or risk for late onset hearing loss.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Monitor hospital newborn hearing screening rates and assist in addressing screening barriers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue home birth newborn hearing screening outreach and monitor impact on screening rates.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue software and technical assistance to birthing hospitals to facilitate reporting of screening results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Develop database linkages to identify infants who may not have received hearing screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Develop/disseminate public awareness materials on early hearing detection and intervention (EHDI).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Continue education/training for hospital screening staff, audiologists, and other providers about EHDI.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Promulgate administrative rules for EHDI that are consistent with state newborn hearing screening law.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Conduct research study on causes of hearing loss in children identified through newborn screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Development of improved methodology for measuring uninsured children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Development and implementation of new strategies and models for outreach and enrollment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Require Title V contractors to refer eligible uninsured children for insurance coverage.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Analysis of options for increasing coverage for children, especially those with family incomes betwe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Simplification of Medicaid application for children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Expanding use of electronic Medicaid applications.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Improvement of Medicaid information system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Development and implementation of strategies to improve utilization of EPSDT services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Require Title V contractors to promote EPSDT utilization.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Contracts to provide perinatal support services to high-risk pregnant women statewide.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Contracts to provide outreach and pretreatment services to substance abusing pregnant women.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provides culturally competent services to areas of high risk for infant mortality and morbidity.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

4. Implements action plans related to reducing low birth weight and preterm birth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Supports efforts to improve data quality from birth certificates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Supports community development efforts to increase primary care and perinatal support services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Provides training on smoking cessation for contracted providers of perinatal care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Provides training on oral health education and counseling for providers of perinatal care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Provides suicide prevention education to students and the community.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Improve inter-agency collaboration to build infrastructure needed to support and sustain the Coordinated School Health Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Plans to improve the system of care for children using federal CompCare technical assistance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Identifies suicide prevention strategies by reviewing information surrounding child deaths.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provides training to promote healthy youth development and suicide prevention efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Improves surveillance systems through inter-agency planning efforts to administer 4 school health surveys that collect student health data used for program planning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Utilizes data to conduct needs assessment in collaboration with state/community partners.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Contracts to provide perinatal support services to high-risk pregnant women statewide.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Contracts to provide outreach and pretreatment services to substance abusing pregnant women.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provides culturally competent perinatal support services to areas of high risk for infant mortality and morbidity.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Supports efforts to improve data quality from birth certificates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Conducts research to determine why problem births occur outside of				

tertiary care centers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Assures access from the neighbor islands to tertiary care centers through the air ambulance system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Conducts research on factors contributing to high cost births in Hawaii.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Utilizes data to conduct needs assessment of the adequacy of the perinatal service system in collaboration with state/community partners.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Contracts to provide perinatal support services to high-risk pregnant women statewide.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Contracts to provide outreach and pretreatment services to substance abusing pregnant women.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provides culturally competent services to areas of high risk for infant mortality and morbidity.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provides referral services to uninsured women with positive pregnancy tests to prenatal care providers.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Supports community development efforts to increase primary care perinatal services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Contracts to provide information/outreach to promote the importance of prenatal care.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Implements action plans related to increasing access to for pregnant women.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Addresses delays in Medicaid application processing for pregnant women.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Utilizes data on utilization and access to perinatal services to conduct needs assessment in collaboration with state/community partners.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of women who report use of alcohol, tobacco, and other drugs during pregnancy. [SPM 3]*

a. Last Year's Accomplishments

This measure reflects the State priority to reduce substance use. Data for this measure comes from the Pregnancy Risk Assessment Monitoring System (PRAMS), a population based survey of mothers at 2-4 months after child birth. Using the latest available data, the FY 2002 indicator is 12.0. The objective was met.

The attached table compares the PRAMS data with Healthy People 2010 objectives for substance use during pregnancy. Hawaii met the HP 2010 objective for alcohol use, but not for smoking or illicit drug use.

To decrease harmful substance use during pregnancy, efforts have focused on maternal

health during pregnancy. Title V continued to fund contracts to provide perinatal support services (PSS) to high-risk women statewide. The women are assessed for psychosocial risks such as substance use and smoking. Limited funding also continues for the Baby S.A.F.E. (Substance Abuse Free Environment) programs that provide outreach, early identification, and pretreatment services to substance using pregnant women. Title V funds three programs and the DOH Alcohol Drug Abuse Division (ADAD) funds a similar program on Kauai.

Improved coordination is needed among existing programs to maximize resource utilization. Title V continued to work with ADAD, service providers and the March of Dimes to provide training programs for workers in the area of perinatal substance use.

In November 2002, the S.A.F.E. Council sponsored a two-day, infrastructure building conference entitled "Healthy, Safe, and Sober" for providers statewide to learn about the most current treatment, research, evaluation and policy information in the areas of substance using pregnant and parenting women.

The Title V program, in collaboration with the Hawaii District Health Office continued the Malama A Hoopili Pono program that provides health care services to high risk pregnant women to decrease infant mortality and morbidity. Title V also funds community based programs like the Kauai Malama Project, to provide health services for high risk pregnant women. Clients are screened for substance use and provided counseling or referral for treatment services.

The Title V program partnered with other agencies to develop culturally competent interventions and materials for mothers who smoke during pregnancy. Smoking cessation training for the PSS providers and Hawaii's Healthy Start programs were provided. The WIC program continued to counsel prenatal clients about the harmful effects of tobacco, alcohol and substance use. WIC will make a referral for treatment if requested and all offices prominently display "no smoking" signs.

In March 2003, Title V co-sponsored a Perinatal Summit to bring together State perinatal stakeholders interested in developing strategies to target critical perinatal issues including substance use. A committee was formed to develop an action plan to improve policy, education, outreach, and services that reports to the Hawaii Perinatal Consortium (HPC) quarterly meetings.

b. Current Activities

Title V continues the programs to reduce substance use among pregnant women as described in the previous year's report through contracting and monitoring services for high risk women and provide population based outreach/education programs through partnerships with other agencies. Title V efforts to conduct a review of the Baby Safe program ended due to the departure of staff. Program monitoring has been hampered due to a position vacancy. Recruitment efforts are underway to fill the position.

The Perinatal Support Services sites continue to provide smoking cessation education to pregnant smoking women. The PSS and District Health Office staff received funding from the Tobacco Prevention program to train staff on smoking cessation.

PRAMS continues to collect data on alcohol, substance use and smoking during pregnancy. Results for 2000-01 are being disseminated through presentations and publications. FY 2002 is being analyzed.

Reducing illicit drug use has become a state priority issue, particularly the use of methamphetamine. Statistics from criminal arrests, the Medical Examiner's Office and drug

treatment programs indicate Hawaii leads the U.S. in use of this drug. A state drug control strategy was developed that balances enforcement, prevention and treatment approaches.

Health professionals continue to provide education about drug dependency as a serious medical condition, presenting scientific data documenting the highly addictive nature of substances like methamphetamine. Advocates also report the dangers of treating addiction as a crime, discouraging drug-addicted mothers from seeking prenatal care and avoiding hospitals to deliver their babies.

Over 50 organizations and medical professionals publicly appealed to the Honolulu Prosecutor to drop manslaughter charges against a drug addicted mother who's infant died 2 days after birth, arguing that prosecution would discourage pregnant drug abusers from seeking adequate care for themselves and their unborn babies. In an agreement, the mother pleaded no contest to a manslaughter charge and received probation.

Title V continues to contact Healthy Mothers, Healthy Babies (HMHB) for perinatal advocacy efforts. HMHB sponsored an educational forum in November with pediatrician Dr. Chris DeRauf on the effects of prenatal methamphetamine use on child development. HMHB is also working with Title V staff to plan the next Perinatal Summit. Substance use will be an area of focus.

The S.A.F.E. Council continues to meet quarterly to further develop the infrastructure to address substance abuse during pregnancy.

A conference on Fetal Alcohol Syndrome (FAS) was held in March to increase awareness about the condition and appropriate prevention/intervention strategies. The Title V agency Medical Director attended the national FAS Conference in Florida. Information gained from the conference will be useful for planning and implementing services to reduce the incidence of alcohol use during pregnancy.

c. Plan for the Coming Year

Objectives for the measure have been revised based on the FY 2000 indicator (the first full year of PRAMS data) and reflects a 0.5% decrease each year. Data for 2003 is expected from the CDC in FY 2005.

The Title V program will continue to provide infrastructure building training opportunities for service providers to identify and assess substance use and to expand the capacity to treat substance-using pregnant women. Providers are concerned about the impact of managed care on treatment availability and duration. The Title V program will continue to work with providers to identify managed care issues which impact on best practice and desired outcomes for pregnant women.

Title V continues to contract HMHB for perinatal advocacy efforts. In conjunction with the HPC HMHB will continue to coordinate statewide meetings for the Perinatal Advocacy Network (PAN) to discuss and address current perinatal issues and host perinatal research presentations. As current studies and research become available on methamphetamine and effects to the fetus, the HPC and PAN members will be kept informed.

Quarterly S.A.F.E. Council meetings will provide a forum for discussion of these pertinent practice issues. The meetings support information-sharing and interagency partnerships to improve statewide system functioning.

WIC will continue implementing its policy to provide pregnant clients information about the harmful effects of substance use and smoking. If clients choose to seek treatment to reduce or

end substance use, WIC makes an appropriate referral to a treatment program.

The Perinatal Support Services (PPS) will also continue health education and referral to pregnant high-risk women for substance abuse treatment and intervention services. The PSS programs will continue to train more direct service staff. The PSS programs will also seek additional tobacco prevention funding to receive expand training opportunities for providers.

The S.A.F.E. Council in conjunction with the Salvation Army Drug Treatment program will continue to provide training courses on substance use and parenting for the employees of the Department of Human Services Child Protective Services. The organizations will also facilitate infrastructure-building meetings among the state's substance use outreach and treatment workers to facilitate networking and dissemination of critical information.

The Title V program will continue to collect PRAMS data. FY 2000-03 data will be analyzed and disseminated to perinatal service providers, policy makers, and the general public. A few revisions to the 2005 questionnaire will be made concerning HIV, post-partum depression, breastfeeding, and general health evaluation. The PRAMS data will also be used extensively for the MCH needs assessment. The Title V agency will complete the MCH needs assessment working in collaboration with state/community stakeholders in July 2005.

State Performance Measure 2: *Percent of teenagers in grades 9 to 12 attending public schools who report smoking tobacco within the last 30 days. [SPM 5]*

a. Last Year's Accomplishments

This measure reflects the State priority to reduce substance abuse. The 2003 objective was met and exceeds the Healthy People 2010 objective of 16%. However, the 2001 and 2003 Youth Risk Behavior Survey (YRBS) results are unweighted and is not representative of all Hawaii public high school students.

To improve data infrastructure, the interagency Adolescent Survey Committee (ASC) developed a coordinated process to administer 4 school health surveys funded by Department of Health (DOH): YRBS; the Youth Tobacco Survey (YTS); the Student Drug and Alcohol Use Survey; and Health/Physical Education Standards Survey. Coordination is needed to minimize disruption of classroom instruction and encourage participation to generate maximum response rates for weighted data. In the past, the surveys were conducted separately at different times, using different sampling methods. In FY 04 the surveys will be conducted during a school survey week with all students completing one of the surveys.

Youth smoking prevention programs are located across DOH and provide population based and infrastructure building services. The Tobacco Prevention and Education Program (TPEP) is the lead agency with the REAL program, which empowers youth to develop strategies to reduce tobacco use. REAL is administered by the University's Cancer Research Center (CRC). Strategies from the Centers for Disease and Control (CDC) include counter-marketing, school-based prevention, community mobilization, policy and regulation. TPEP sponsors the YTS, sponsors training on media literacy, oversees media campaigns, and supports Tobacco-Free Neighbor Islands Coalitions.

Other substance abuse prevention efforts are funded by a federal State Incentive Grant (SIG) administered by the DOH Alcohol and Drug Abuse Division (ADAD). A State Substance Abuse Prevention Strategy was developed by an Advisory Committee of public/private stakeholders to provide guidance for the allocation of funding. ADAD awarded 5 new SIG community grants to conduct substance use prevention activities. ADAD also works with the CRC and county police departments to stop illegal sale of tobacco to minors and oversees the Student Drug

Use Survey.

Tobacco prevention is one of 6 Coordinated School Health Program (CSHP) goals. The DOH Hawaii Health Initiative (HHI) with Tobacco Settlement Funds supported a Summer Institute teacher course on prevention education for tobacco and other drug use. Tobacco Settlement Funds support the REAL Program that empowers youth to reduce tobacco use. The DOE Peer Education Program offers smoking cessation education to students in the 26 public schools.

The Lieutenant Governor's Office is coordinating efforts to implement the State Drug Control Plan developed in response to a groundswell of community concern. The plan balances prevention, treatment and law enforcement approaches with a focus on organized youth activities during non-school hours. SPM 08 describes these program efforts in more detail.

b. Current Activities

The ASC continued planning and helped implement the first coordinated effort to conduct the 4 health surveys in the schools. The survey contractor, the University Curriculum Research and Development Group (CRDG), created a management information system to track consents and support survey distribution.

To encourage parental consent and awareness of survey benefits, 143,000 pamphlets with 2000-01 school survey results were printed and distributed to all 6th to 12th grade students for their parents. The pamphlet data is also supporting grant writing by agencies and community groups, and promoting discussion of health behaviors in the classroom as well as at home.

CSHP activities have been redirected to focus on strengthening state-level infrastructure within and between the DOE and DOH. Hawaii applied for and received CDC funding to support CSHP. Under the original pilot project, 2 CSHP school sites received a final year of funding to conduct health promotion activities.

DOH's HHI continues to support DOE Health and Physical Education staff, resources and trainings such as the State Health Education Conference to provide teachers and health educators with current health information and teaching ideas. The TPEP in collaboration with the DOE provided teacher training on the effects of media on youth behaviors. The CSHP worked with the University College of Education to provide a graduate teacher education course on media literacy.

TPEP continues work to build community-level infrastructure by supporting Neighbor Island Community Coalitions and the Statewide Coalition. The coalitions conduct activities such as Youth Summits that teach teens how to tailor tobacco messages for peers and communities. TPEP completed Tobacco Cessation Brief Intervention certification trainings throughout the state. On Kauai, schools trained teachers, counselors, coaches and students to deliver brief interventions. TPEP and its partners have developed a network to plan strategies which target Filipino and other populations at particular risk of smoking tobacco.

The 18 SIG funded community projects will continue to implement and evaluate substance abuse prevention programs. The Hawaii Substance Abuse Prevention Advisory Committee (HSAPAC) provides guidance for SIG funded activities. The Committee identified the six major state departments that fund prevention: DOH, DOE, DHS, Housing, Attorney General and Transportation. HSAPAC recommended these agencies improve coordination and drafted a Memorandum of Agreement for review and adoption.

The Legislature passed a measure that prohibits the use of tobacco by employees in public schools in compliance with similar federal mandates. The Hawaii law expands smoking restrictions to all adults including parents, supporters, employees, or others attending school

functions. The Governor signed the bill into law.

c. Plan for the Coming Year

Objectives for this measure have been set to achieve the Healthy People 2010 objective of 21% in 2010. Because YRBS data has been unweighted for the last 2 survey periods it is difficult to determine whether progress is being made. Unfortunately, corroborating data from the 2003 Hawaii Youth Tobacco Survey (HYTS) of 9th to 12th grade high school students is also unweighted. Survey results are not yet available.

Although data is unweighted, the 2003 sample is substantially larger than previous years. Alternative methods will be explored to weight the data. Funding will be sought for publication and dissemination of the 2003 findings.

The PEP and REAL youth programs will continue activities to reduce student tobacco use. ADAD will continue law enforcement activities among retailers to curtail sale of tobacco products to minors.

TPEP will continue to provide teachers with media resources to demonstrate the effectiveness of counter marketing to prevent smoking among youth. DOH HHI continues to fund community based prevention programs. For example on Kauai, a project financed with Tobacco Settlement Funds is the "Alternative to Suspension" program in the schools where students caught smoking receive cessation counseling in lieu of suspension.

TPEP will expand Brief Cessation Certification Trainings and is planning an Oahu Cessation Summit in the Fall targeting personnel from the DOE. The Kauai alternative to suspension program will be featured as a model for other school sites. Administrators and school counselors from three rural Oahu School Districts (Leeward, Central, and Windward) will be provided cessation intervention training as an alternative to school suspensions.

Other community efforts include Tobacco-Free Coalition expansion with the hiring of an island coordinators for the rural island of Molokai and heavily populated Oahu to develop community support to target a variety of disparate populations with higher rates of tobacco use.

Meetings to improve CSHP infrastructure at the state-level will continue among staff from the DOE, DOH and the University. The collaborative work has the full support of the DOH Director and DOE Superintendent and will help clarify the roles and responsibilities of each agency to promote school health. Issues that have been addressed as a result of this collaborative work include childhood obesity, drug use and abuse, school vending machines and school breakfast programs.

The School Health Leadership Institute is being established to provide in-service trainings to 4 CSHP pilot complex sites (Maui complexes are Baldwin, Lahaina and King Keaulike; and the Kauai Area Complex includes the entire island). The Institute will provide training to develop team building, facilitation, leadership and program planning skills. Limited funds will be allocated to selected complexes for program implementation.

The HSAPAC will work towards the adoption of the MOA for coordination of prevention services among State Departments.

State Performance Measure 3: *Rate of confirmed child abuse/neglect reports per 1,000 for children aged 0-5 years. [SPM 7]*

a. Last Year's Accomplishments

The measure reflects the priority to reduce family violence and child abuse and assure parenting support and information is made available to all families. The FY 2003 indicator is 15.9. The objective was not met.

According to Child Welfare Services (CWS), the number of reports is increasing, largely due to the growing methamphetamine use and prenatally exposed newborns. The number of children entering foster care is also increasing.

CWS data reflects a portion of all abuse cases-those that occur in the home. Other sources of data include the Children's Justice Centers, which provide forensic interview and counseling services to victims of non-family sex abuse. The Centers receive 1200-1400 reports per year, about one-third of them concern children ages 0-5. However, most of the Centers' clients were abused years before.

Much of Title V's efforts are assurance activities through contracting of services and monitoring. DOH continued its ongoing contracts with nonprofits for the provision of family strengthening and family support services for the prevention of child abuse and neglect. Title V administers two population-based programs: Hawai'i Healthy Start universal screening to identify families at risk for child abuse and neglect and a parenting advice phone line. Of those families receiving Healthy Start services, 99% had no confirmed reports of child abuse or neglect.

Title V also co-sponsored the annual state child abuse and neglect conference.

Title V's targeted programs including home visiting of families identified as at-risk, parent support groups, outreach to pregnant and new mothers who use substances, parent/child play groups, respite, and counseling services for children who witness violence. These ongoing programs have served as the core of DOH's family violence prevention services for many years. Title V administers the Hawaii Children's Trust Fund, which contracts for targeted service provision to support families and prevent child abuse and neglect.

The Coordinated School Health program, conducted in conjunction with the Department of Education, funded resource personnel to implement health content and performance standards that includes violence prevention education. The standards assure children in the public schools will receive violence prevention information as part of the health curriculum.

The Hawaii Child Death Review continued its work to reduce preventable deaths to children, including cases of child abuse and neglect, by partnering with organizations to educate the public about causal factors and advocate for policy or administrative changes.

Efforts to reduce child abuse and neglect at the systems of care level are scattered throughout the state, implemented by various coalitions, councils and boards. Title V staff participate on these groups.

b. Current Activities

The Title V MCH Branch established a Violence Work Group that continues to integrate violence prevention strategies within the Branch programs. In 2004, Title V targeted education efforts at school children. Through contracts, teen dating violence and sexual violence awareness are taught to middle and high school students.

Title V continued to operate its two population-based services, Healthy Start and ParentLine. To date, Hawaii Healthy Start has served 69.4% of eligible families (11.1% of all civilian births); 99% of these families have had no confirmed reports of child abuse or neglect. For more

information on Healthy Start see narrative for SP 14.

Contracts for Family Support programs also continued. Using the Hawaii Children's Trust fund, Title V co-sponsored the annual state child abuse conference.

Title V continue efforts to network, coordinate and plan, and develop policy through active participation on numerous coalitions and councils that advocate for the well being of children and families. These partnerships function at the state policy level and at the community level:

- Legislature's Keiki Caucus community input group, Legislature's Child Protection Roundtable, School Readiness Task Force, Hawaii Children's Trust Fund Advisory Committee, Injury Prevention Advisory Committee, The Awareness Foundation/Violence Prevention Consortium Steering Committee, Title IVB-2 Statewide Council, Child Death Review State Council, Military Family Advocacy Coordinating Council, Child Safety Collaborative, and Good Beginnings Alliance; and

- Hawaii Children's Trust Fund Coalition, Keiki (Child) Injury Prevention Coalition, Never Shake a Keiki (Child) Task Force, Healthy Mothers Healthy Babies Coalition, Maui Coalition to End Abuse, Prevention Hui, Conversation on Forgiveness for Youth (COFFY), and Coalition for Dads.

Child Death Review program has finally compiled the enough data from years 1997-2000 to begin writing a report. The report is scheduled for release in the fall of 2004. The Child Death Review Program is also revising its policies and procedures manual, and planning a scene-investigation training for the summer of 2004.

The federal Child and Family Services Review (CFSR) of Hawaii was completed in November 2003. The DHS was found to be in conformity with only 1 of 6 outcome factors and 2 out of 7 systemic factors. The Department of Human Services (DHS), which houses the CWS, has submitted its mandated Performance Improvement Plan and is awaiting federal approval of the PIP before implementing in July.

The 2004 Legislature extended the work of an interagency task force charged with developing a plan to coordinate services provided by Hawaii Healthy Start and the CWS. The task force is developing agreements between the programs to permit HHS to provide case management services to CWS children and is implementing a general plan for data sharing. The task force will submit a report of findings and recommendations to the 2005 Legislature.

c. Plan for the Coming Year

DHS will continue work to improve CWS as part of improvement efforts initiated by the federal Child and Family Services Review. Findings of the interagency task force responsible for improving coordination between CWS and Hawaii Healthy Start should be completed for the 2005 Legislature.

Major challenges to improving child welfare services will be the state's budget cuts and the Governor's restrictions on spending for new child welfare positions. DHS reports there are an increasing number of repeat child abuse cases, and an increasing number of children in the foster care system. The program's biggest concern is that it cannot hire additional staff for expanded diversion services.

Title V will review a new requirement included in the direct services contracts for primary health care, family planning and perinatal health that establishes protocols to address violence in the clinic setting and as part of client services. Protocols address child abuse and neglect, elder abuse, intimate partner violence, and sexual assault. The two year contracts will be in

effect until June 30, 2005.

Hawaii Children's Trust Fund will continue to administer community-based grant making activities. The Child Death Review will use their data report to develop prevention policies and strategies with their partners. Hawaii Healthy Start will continue its community-based, family centered support with interagency coordination.

Plans are underway to implement a new enabling service in 2004. In partnership with the Interagency Council on Immigrant Services, MCHB plans to develop an Immigrant Parent Handbook for foreign newcomers. This project is enthusiastically supported, particularly in light of the ever increasing number of immigrants moving to Hawaii. Based on information gathered via focus groups, the Handbook will provide explanatory information on health, social service and educational resources pertinent to parents. It will include a friendly yet cautionary message that child and spouse abuse are socially unacceptable and illegal in Hawaii and the USA.

As part of the Title V five-year needs assessment, a population work group on children and youth was formed in 2003 that includes broad representation from across the Title V agency. An evaluation of existing priority needs was conducted in Spring 2003 with key stakeholder input. The issue of violence, including child abuse, was found to be a continuing priority need for this population. Broad stakeholder input was compiled to identify priority issues for children and youth. Further input will be sought for problem analysis and strategy design for the priority needs selected. The report will be completed by July 2005 and include data on child abuse and family violence.

State Performance Measure 4: *Percent of teenagers in grades 9 to 12 attending public schools who report being involved in a physical fight within the last 12 months. [SPM 8]*

a. Last Year's Accomplishments

This measure reflects the State priority to reduce family violence. Data for this measure comes from the Youth Behavioral Risk Surveillance (YRBS), which is conducted bi-annually in the public schools. The 2003 indicator is similar to 2002, 26.0% of high school students report being involved in a physical fight. The 2003 objective was met and exceeds the HP 2010 objective of 33.3%.

Determining progress for this measure is problematic, however, because the 2003 YRBS data, like the 2001 YRBS data is unweighted and represents only the students surveyed and is not representative of all Hawaii public high school students. The 2003 sample is substantially larger (n=8,541) than 2001 (8,541 vs. 1,057), falling just short of the Centers for Disease Control threshold for weighting. Alternative methods are being explored to weight the 2003 data.

The Department of Education (DOE) also reports data on students suspensions indicates a troubling increase in violent offenses that include insubordination, disorderly conduct, harassment, and assault. However, increases may have resulted in part from greater emphasis on dealing proactively with violence. And none of the public schools in Hawaii has been identified as a "persistently dangerous school" as defined in the federal "No Child Left Behind Act."

See SPM 5 on teen smoking for information on efforts by the Adolescent Survey Committee (ASC) to improve data collection for the school surveys, Coordinated School Health Program activities to address risk behaviors, and health education efforts.

Title V population based programs focus on violence prevention education and outreach. Title V contracts with the Sex Abuse Treatment Center (SATC) at the Kapiolani Medical Center and DOE Peer Education Program (PEP) to provide sex assault prevention education to youth statewide. PEP educators provided 389 middle and high school sex assault presentations to 13,686 students and 834 students were provided one-to-one sex assault education. PEP educators also provided sex assault information to 19,858 parents through various methods including flyers.

SATC provided training to agency staff serving populations with disabilities, immigrants and runaway youth. The Hawaii Coalition Against Sexual Assault (HCASA) partners with the sexual assault providers to increase public awareness about sexual assault through activities during Sexual Assault Awareness Month. The State Domestic Violence Prevention (DV) Special Funds supported contracts for violence prevention including sex assault prevention for teens and general violence prevention education.

b. Current Activities

The ASC continues work to improve school health survey data collection. DOE's Comprehensive Student Support System (CSSS) is being developed to assure all students have a multi-faceted system of supports. A database to track program indicators was completed. Indicators include "every child has a relationship with one caring adult in the school."

See PM 16 and SPM 05 for information on the Healthy Hawaii Initiative funding for the University Summer Institute teacher training to promote resiliency in youth and safe environments.

Title V was one of 4 sites selected to receive technical assistance as part of the "Building Partnerships for Youth Project" (BPY) offered by the University of Arizona (UOA) and funded through the Centers for Disease Control. The project is designed to promote healthy youth development. The Hawaii project focused on strengthening partnerships to develop non-school hour programming and reflects best practices described in the State Adolescent Wellness Plan and the Hawai'i Substance Abuse Prevention Strategy. It also supports youth drug prevention programs proposed by the Lt. Governor's Office as part of the State Drug Control Plan.

A review of current theory/research in youth development and non-school hour programming was presented via statewide video conferencing to over 130 participants by Dr. Shepherd Zeldin, noted researcher in adolescent development. CD copies of the presentation were provided to each participant and sent to other community stakeholders. The project resulted in many new partnerships between youth programs.

The MCH Branch received an American Public Health Association (APHA) Community Leadership Institute award. Technical assistance and training in the area of youth violence prevention will be provided to the 5 member team.

The DOE PEP continued sexual assault prevention education to youth at 26 public schools. SATC continued to provide sex assault training to health agencies. SATC also developed a sexual assault prevention curriculum for use in Hawai'i schools.

DV Special Funds continued to support teen dating violence prevention activities and helped sponsor "Girl Fest", a series of violence prevention activities and resources targeted to young girls/teens. Activities included a gender violence workshop conducted by national violence prevention advocate, Jackson Katz. Funds also supported The Awareness Foundation, a broad coalition of service providers that are developing a unified approach to violence

prevention. The DV Funds were also used to provide counseling services to young children exposed to domestic violence in the home.

HCASA activities during Sexual Assault Awareness Month included an information campaign on child sexual assault, public service announcements on television, a Neighbor Island poster campaign, and O?ahu flier-handbill campaign promoting the hotline number for sexual assault services.

c. Plan for the Coming Year

Objectives for this measure have been set to assure the Healthy People 2010 objective of 21% is achieved by the year 2010. However, because YRBS data has been unweighted for the last 2 survey periods it is difficult to determine whether progress is being made toward this objective.

Hawaii BPY participants received CD copies of the PowerPoint presentation on after-school hour programming and are now using the presentation to build partnerships, and provide training on healthy youth development approaches. Title V is using the BPY materials to provide technical consultation to the Department of Human Services (DHS) on non-school hour programming. DHS will be using surplus Temporary Assistance for Needy Families (TANF) funds to provide more non-school hour programs for youth throughout the state. The programs are designed to prevent teen pregnancy using a healthy youth development approach and are also an essential prevention component of the State Drug Control Plan.

SATC will continue to train agency and professional staff on sexual assault prevention and intervention. SATC will continue to provide educational resources to the community. The DOE PEP program will continue violence prevention education in Hawai'i public schools. DVP Special Funds will continue to support youth violence prevention activities. HCASA will continue to carry out public awareness activities.

The UH College of Education course will continue its teacher trainings supporting the CSHP and healthy youth development. The Hawaii APHA Team will continue to assess ways they can reduce violence and promote positive youth development. The ASC will address ways to promote survey data utilization and related program planning as discussed in SPM 05.

As part of the Title V five-year needs assessment, a population work group on children and youth was formed in 2003 that includes broad representation from across the Title V agency. An evaluation of existing priority needs was conducted in Spring 2003 with key stakeholder input. The issue of violence, including teen fighting and bullying, was found to be a continuing priority need for this population. Broad stakeholder input was compiled to identify priority issues for children and youth. Further input will be sought for problem analysis and strategy design for the priority needs selected. The report will be completed by July 2005 and include data on teen fighting and family violence.

State Performance Measure 5: *Percent of pregnancies (live births, fetal deaths, abortions) that are unintended. [SPM 11]*

a. Last Year's Accomplishments

This measure reflects the state MCH priority to reduce the rate of unintended pregnancies in Hawaii. The FY 2002 indicator is 53.4% using the latest available data from the Pregnancy Risk Assessment Monitoring System (PRAMS) as well as vital statistics data on abortions and fetal deaths. The objective was not met. The Goal for Healthy People 2010 is to decrease unintended pregnancies to 30%. Rates for the U.S. range from 60% to 49%.

In an effort to reduce unintended pregnancy in Hawaii, DOH's Family Planning Program (FPP) provided family planning (FP) community health education and outreach services on six islands as well as clinical FP services for uninsured women and men at 46 clinic locations statewide.

Direct services included comprehensive FP clinical visits; enabling services include FP health education, translation services, case management, referrals, and information on health insurance, WIC, and other appropriate services. In 2003, Title X FP funds provided 21,459 subsidized clinical FP visits to uninsured individuals through contracts with community clinics statewide.

Population based programs included media campaigns that focused on Emergency Contraception (EC) and access to FP services. Public service announcements, presentations, health fairs, and distribution of education/promotional materials were used. Community clinics were encouraged to be listed on national EC Hotlines and websites. In 2003, 2,234 EC visits were provided.

Prevention efforts, through presentations and media initiatives by community Health Educators (HE), are targeted to high risk individuals such as adolescents, women not likely to seek health services, males, homeless, the disability community, and substance abusers.

Activity around teen pregnancy prevention is increasing with support from surplus TANF funds. See narrative PM 08 for this and other activities targeted at adolescents.

Infrastructure services included monitoring contract performance by FPP staff through site visits, record review, collection of client visit data, and reports on progress with performance measures. FPP worked with providers to improve the quality of client datasets to develop reports useful for program evaluation and planning. Title V staff provided ongoing training to clinic data entry staff, reviewed common data errors, and identified strategies to improve the data collection system. Renewed activity in this area has resulted in vast improvements in data quality, timeliness of reporting, and greater collaboration with providers.

An EC interagency workgroup was successful in passing legislation which allows pharmacists to dispense EC through collaborative agreements with physicians. This makes Hawaii the 3rd state in the nation to have passed a state law on EC pharmacy access. A bill which would require all hospitals to inform sex assault victims about EC and provide them if requested was vetoed by the Governor.

b. Current Activities

In an effort to reduce unintended pregnancy in Hawaii, the FPP offers preventive FP services as described in the previous FY 2003 report and assures access to clinical services by contracting with community clinics on six islands to provide subsidized family planning services to uninsured women and men at 46 clinic locations statewide.

The FPP collaborates with partners to provide population-based community health education and outreach services. Although limited to half-time positions, the health education contracts continue with nine FP health educators providing FP presentations statewide.

The EC promotion campaign continues outreach and education activities through presentations, public service announcements, plays, and health clinics. The EC interagency workgroup meets to collaborate on EC access and track the implementation progress of the EC bill passed in 2003. Implementation is pending the adoption of administrative rules, which would allow pharmacists to dispense EC in pharmacies throughout the state by collaborative

agreements with physicians.

The M.A.N. Project, through Waikiki Health Center's Youth Outreach Program, involves males in FP by providing health education and clinical services. The target group is male street youth who are mostly homeless. The number of males served increased by 62%, although most FP services are still being provided to females. See PM 8 narrative for other activities targeted at adolescents.

Major efforts are being made to improve the FP provider data system to comply with additional Title X reporting mandates that require more detailed client information (e.g. ethnicity and STD testing). A contractor is being hired to design new software for the data system. The software will also allow FP providers to print several standard reports on their respective client datasets. Currently, the software has no reporting capacity. These reports will expand provider capability to monitor, evaluate, and report on service delivery progress over any given timeframe.

Providers have requested this ability to better target limited resources (especially for health education to certain ethnicities), do routine reporting to their Boards, and develop grant proposals. Currently, all report requests for providers are submitted to the FP program office. This development will allow MCHB research statistician staff to focus on compiling and analyzing statewide provider data for quality assurance and monitoring health trends/services for this high-risk population. The new software should be installed and operational in 2005.

c. Plan for the Coming Year

The indicator data comes from PRAMS and vital statistics data on abortions and fetal deaths. Weighted data for the 2003 PRAMS should be available in 2005 from the Centers for Disease Control. Objectives for this measure have been set to ensure Hawaii achieves the Healthy People 2010 objective by the year 2010.

Title V is re-evaluating the broad definition of "unintendedness" and whether the current results from PRAMS are useful in identifying the women most in need of limited FP resources. The PRAMS Project Coordinator and MCH Epidemiologist are analyzing the unintended responses from the PRAMS survey to identify those pregnancies that are "wanted", "unwanted", "ambivalent", and "mistimed." Results have been presented in a Title V Work Group and are being developed for eventual publication. The Work Group will continue to meet to analyze results to capture the complexity of circumstances under which women unintentionally get pregnant. The group will use the data as a basis to identify high-risk groups, gaps in services, and strategies to reduce unintended pregnancy in Hawaii.

The FPP struggles to broaden its focus on provision of clinical services to a larger public health approach to prevent unintended pregnancy. A multifaceted, multi-program approach is needed to address prevention efforts targeted at reducing unintended pregnancy in the population at large. Leadership and additional funding beyond Title X are needed to spearhead prevention efforts.

Media campaigns are effective tools in the prevention of unintended pregnancy by increasing community awareness of the problems associated with unintended pregnancies, the importance of family planning, and access to subsidized services. However, resources to contract media are in short supply.

The clinical/enabling services and health education contracts will continue as described in the previous narrative. Teen prevention programs continue. See narrative for NP 08 on teen births. Work to improve provider contract data will also continue. Through this work, MCH data staff is also identifying potential areas to build a more integrated data system to track all the contract service data.

The FPP will look to federal agencies and national organizations for leadership and information about best practices to reduce unintended pregnancy, such as Office of Population Affairs, National Campaign to Prevent Teen Pregnancy, National Family Planning and Reproductive Health Association, Not-2-Late Emergency Contraception Campaign, Advocates for Youth, and Unintended Pregnancy Prevention of Division of Reproductive Health of CDC.

State Performance Measure 6: Percent of infants with hearing loss who are receiving appropriate intervention services by age 6 months. [SPM 12]

a. Last Year's Accomplishments

The FY 2003 indicator was 72.5 and did not meet the objective. The data is preliminary. FY 1999-02 data has been updated to conform to reports submitted to the national Early Hearing Detection & Intervention (EHDI) Program.

The Newborn Hearing Screening Program (NHSP) provided information to families of infants with possible hearing loss or risk factors for late onset hearing loss about accessing recommended audiological follow-up and early intervention services. As needed, diagnostic audiological evaluations and transportation support were arranged. Infants with permanent hearing loss were referred for early intervention services.

NHSP is a program in the Early Intervention Section (EIS)/CSHNB, which provides early intervention services for infants/toddlers 0-3 years who are developmentally delayed or biologically/environmentally at risk, as mandated by Part C of Individuals with Disabilities Education Act (IDEA).

Workshops for early intervention care coordinators and specialists included training on basic audiology, hearing aids, audiological services, cochlear mapping/aural rehabilitation, and early hearing detection and intervention. Working relationships with pediatric audiologists were maintained to facilitate timely and appropriate evaluations for infants who failed screening.

Publications included "Information for Early Intervention Specialists" and "Let's Listen" booklet for parents.

A lending library of videos and other materials provides families/staff with practical information on the management and medical/educational/communication aspects of hearing loss. The library also has educational toys for children who are deaf or hard-of-hearing. Libraries are located at the NHSP office and at early intervention programs on all islands.

A Deaf Mentor/Parent Advisor pilot was established. Using SKI*HI Deaf Mentor and Parent Advisor training, the project provides individualized family support to assist families in learning about deaf culture, understanding the needs of infants with hearing loss, and learning communication techniques to foster language development. Development of the project began in May 2002. Deaf Mentor training was held in 2003 with six families participating.

The Early Intervention (EI) Hearing Specialist (Deaf Educator) assisted early intervention programs, providers, and families in serving children with hearing loss. Working relationships were developed with organizations that serve the deaf community in Hawaii, including Gallaudet University Regional Center, Hawaii Services on Deafness, Hawaii Center for the Deaf and Blind, and Kapi'olani Community College American Sign Language (ASL) Interpreter Program. The Hearing Specialist made home visits to provide communication options, ASL instruction, auditory training, literacy activities, and general information on hearing loss issues to families.

Funding support is from the Hawaii Early Childhood Hearing Detection and Intervention project (MCH Bureau grant) and Part C of IDEA.

b. Current Activities

NHSP continues to provide information to families of infants with possible hearing loss or at risk for late onset hearing loss about accessing services. As needed, audiological evaluations and related transportation support are arranged, and infants with permanent hearing loss are referred for early intervention services. Diagnostic results of audiological evaluations authorized/paid by EIS, confirmed hearing status, amplification, and early intervention enrollment status are monitored and tracked. Flow charts/ protocols of services from newborn hearing screening to early intervention have been drafted.

The EI Hearing Specialist provides early intervention services for children under age 3 years with hearing loss and their families. Services include providing information on communication options, communication strategies and language development activities for parents to use with their children; providing ASL instruction; participating in Individual Family Support Plan meetings; explaining audiological reports; referring families of children with hearing loss for other community services; and providing instructional materials. The EI Hearing Specialist also provides transition support into Department of Education or other programs (e.g., Head Start, community preschools). Language Enrichment Playgroups are provided as needed to enhance language development and communication skills through sign language and speech.

A Deaf Mentor and Parent Advisor Program is being piloted on Oahu and monitored for developmental impact and family satisfaction. Training was provided to Parent Advisors in October and December 2003. Follow-up training is being provided for Parent Advisors in 2004. Monthly meetings are held with Deaf Mentors and Parent Advisors to evaluate and improve the program. Six families continue to participate in the pilot.

Inservice training is provided for care coordinators, early intervention providers, Deaf Mentors and Parent Advisors to improve understanding of how hearing loss can affect development and to improve quality of early intervention services for children with permanent hearing loss. Consultation is provided to care coordinators regarding treatment planning and requesting hearing aids and other amplification devices through EIS. Lending library resources continue to be used.

CSHNB collaborated with the University of Hawaii/School of Medicine/Department of Pediatrics in arranging March 2004 educational sessions on mild hearing loss by Dr. Noel Matkin for pediatricians, audiologists, speech pathologists, social workers, public health nurses, and other providers.

With funding from the Centers for Disease Control and Prevention, CSHNB is conducting a research study of the service history and developmental status of children with congenital hearing loss in Hawaii. Participating parents complete a detailed questionnaire, and information is collected from providers and schools who know the child.

c. Plan for the Coming Year

Objectives for FY 2004-2007 were revised based on the updated indicators for FY 1999-2003. Preliminary data for FY 2003 will be updated.

NHSP will continue to provide information to families of infants with possible hearing loss or at risk for late onset hearing loss about how to access recommended audiological follow-up and

early intervention services. As needed, audiological evaluations and related transportation support will be arranged, and infants with permanent hearing loss will be referred for early intervention services. Diagnostic results of audiological evaluations authorized/paid by EIS, confirmed hearing status, amplification, and early intervention enrollment status will continue to be monitored and tracked.

The EI Hearing Specialist will continue to provide direct services to families and will begin facilitating support groups for families with children with hearing loss. Input will be obtained from families regarding the types of services they are seeking and will compare hearing loss configuration with types of services families are seeking.

The Deaf Mentor and Parent Advisor pilot project will continue. Inservice training and consultation to care coordinators and program staff will continue. ASL workshops will be offered to program staff as needed. The lending library will continue, and educational materials will be updated.

The research study to examine service history and developmental status of children with congenital hearing loss in Hawaii will continue. The study is scheduled for completion in December 2005.

State Performance Measure 7: *Percent of teenagers in grades 9 to 12 attending public schools that are overweight. [SPM 13]*

a. Last Year's Accomplishments

Data for this measure comes from the 2001 Youth Behavioral Risk Surveillance (YRBS), conducted bi-annually. The 2003 YRBS data indicates 13.2% of the public high school students surveyed are overweight. The FY 2003 objective was not met.

Determining progress for this measure is problematic because the 2003 YRBS data, like the 2001 data, is unweighted: reflecting the responses of the students surveyed. It is not representative of all Hawaii public high school students. See the narrative for SPM 05 for efforts to secure weighted data for YRBS.

Other data sources for children's weight are being sought by the Department of Health (DOH). The Community Health Division (CHD) is compiling data from health forms submitted at the time of kindergarten entry. The forms are completed by a physician, thus considered more reliable than self-reporting. According to the data from Pediatric Nutrition Surveillance System provided by WIC, Hawaii rates for overweight children under 5 years of age are comparable to national rates.

There is substantial activity in the State to promote better nutrition and physical activity for school age children through the DOH Healthy Hawaii Initiative (HHI) using funding from the Tobacco Settlement. Through HHI, DOH partnered with the Department of Education (DOE) to develop a Coordinated School Health program (CSHP) to improve nutrition, increase physical activity, and reduce tobacco use among public school students.

Resource teachers were hired to implement the DOE Health Education Standards adopted in 1999 to promote skills-based health education to help students practice healthy behavior. The teachers worked with pilot school campuses to develop sustainable health promotion programs and policies. Two remaining pilot sites are completing health projects.

HHI in partnership with other agency support have been successful in building the school health education infrastructure needed to provide on-going professional development and

training for Hawaii's 13,000 teachers in health and physical education. CSHP professional development activities for teachers include health conferences, workshops, technical assistance, and credited university summer courses.

HHI also funded numerous community based health promotion activities. Projects included development of biking/walking paths and establishment of Youth Councils on Healthy Living. HHI also supports Nutrition and Physical Activity Coalitions (NPAC) on the neighbor islands.

HHI continued its public education campaign, "Start Living Healthy," to promote small, achievable changes to improve health. The campaign employed media ads, community activities, special events, a website, product giveaways, and development of community partnerships.

Programs continue to work collaboratively to provide services to increase physical activity and nutrition in children. WIC continues to provide nutrition counseling and food coupons to low income pregnant women and families with young children.

b. Current Activities

Work on a 3-year Coordinated School Health Infrastructure grant from the Centers for Disease Control began by improving interagency coordination and capacity building between the DOH, DOE and University of Hawaii. The goal is to reduce the health risks of children and youth.

Other key CSHP activities include: educating DOE administrators about importance of school health for academic achievement and increasing administrative capacity to support implementation of programs at the school complex level (a high school and its feeder middle and elementary schools). See SPM5 for more details.

DOE's Food Services staff is partnering with the 5-A-Day Coalition to increase cafeteria staff's nutrition knowledge and to provide nutritious lunches and snacks for students. DOE has formed committees to examine different aspects of school nutrition (e.g. contents of vending machines).

Launched at the 2002 Healthy Schools Summit, State teams have been formed to develop a plan to improve children's health. The Hawaii Action for Healthy Kids Team is focusing on changes in the school environment to improve nutrition and physical activity. The team led by staff from the DOE and DOH and includes representation from a broad sector of stakeholders.

The Kapiolani Medical Center's (KMC) Child Obesity Task Force produced a White Paper on childhood overweight and is working on several project ideas including a Body Mass Index Wheel to measure overweight in children for health care professionals. The Task Force was 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.

The "Start Living Healthy" public education campaign is now focusing on more specific health messages. In June a new campaign was launched, "1% or Less Is Best," to help raise the public's awareness of the value of switching to low fat milk.

The Nutrition Education Needs Assessment Survey (NENAS), conducted by the University of Hawaii and the DOH Nutrition Branch, will help provide baseline data related to physical activity, nutritional practices and obesity for students in grades 5, 8 and 10. Data is being analyzed. See SPM 05 for details on the administration of student health surveys.

The DOH Community Health Division continued analyzing data from school health forms submitted at kindergarten. Preliminary analysis of the 9,804 records shows that Hawaii children are heavier than national reference data for that age group. A secondary purpose of this study is to see if the forms can serve as a reliable source for surveillance data.

The Kauai District Health Office also completed a similar study using DOE health forms. Data confirmed that a relatively high percentage of children were entering school overweight.

c. Plan for the Coming Year

Reliable population based data on the weight status of Hawaii's children continues to be a need. Title V staff will continue to focus efforts to find reliable and sustainable population-based data sources to understand the prevalence and the risk factors associated with obesity across the state.

Title V will collaborate with initiatives in schools and communities that propose to collect data on obesity in children. For example, Waianae Coast Comprehensive Health Center, a community health center, and the Kapiolani Medical Center for Women and Children in Honolulu are addressing this problem, convening stakeholders to identify feasible strategies.

The NENAS survey results should be completed by September 2004. Analysis of data will assist agencies that have been relying on anecdotal information, to plan programs for their children and families.

The Community Health Division (CHD) is the lead agency in DOH for programs addressing chronic disease prevention, including obesity. CHD is currently developing an integrated chronic disease management plan which should be completed sometime in FY 2005.

Because of Hawaii's multi-ethnic population, local food choices differ considerably from the nation. To address this, the 5-A-Day Coalition will publish two new brochures with a Hawaii focus-Eating 5 a Day in Hawaii and Eating by Color.

Title V staff will continue to collaborate with the DOH's Nutrition and Physical Activity programs to assure that a two-pronged approach to weight control, nutrition and activity, be integrated into the various MCH Branch programs and contracts.

As part of the Title V five-year needs assessment, a population work group on children and youth was formed in 2004 that includes broad representation from across the Title V agency. An evaluation of existing priority needs was conducted with key stakeholder input. Obesity was found to be a continuing priority need that has not seen sufficient progress over the past 4 years since the last needs assessment was completed. Broad stakeholder input was compiled to identify priority issues for children and youth. Further input will be sought for problem analysis and strategy design for the priority needs selected.

Coordinated School Health Program efforts will continue work to promote good nutrition and increase physical education in schools despite many challenges. CSHP efforts often compete with new academic priorities mandated by the federal "No Child Left Behind" act. Moreover, the DOH Healthy Hawaii Initiative (HHI) is under constant threat from state budgetary shortfalls that have diverted funds for other state priorities.

State Performance Measure 8: *The percent of families assessed to be at risk for child maltreatment that enroll in Hawai'i Healthy Start home visiting support services. [SPM 14]*

a. Last Year's Accomplishments

This measure directly reflects the state MCH priority to assure parenting support and information is made available to all families with children, especially to environmentally at-risk families through Hawaii Healthy Start (HHS), the state's child abuse prevention program. The indicator for FY 2003 is 69.5%. The objective was not met for a second consecutive year. The indicator has been declining since FY2001, 2.6% in FY2002, and another 4.1% in FY2003. The reason for this decline is unclear and is being studied.

The HHS program activities are:

- Identify environmentally at-risk families (including risk of child maltreatment and related issues of substance use, family violence, and mental health issues);
- Engage and retain at-risk families in home visiting services;
- Monitor family risk factors to reduce crisis situations; and,
- Strengthen family functioning via reinforcement of positive parenting skills, normal child development (including developmental screening) and linkages to community resources to reduce risk factors and parental stress.

The first program component is a population-based service of universal screening. In FY 2003, 2,315 families were positively identified as being environmentally at-risk (16% of births) and 69.4% of these families (approx. 11% of births) voluntarily enrolled in Healthy Start while 6.3% choose instead to engage in other, comparable home visiting programs within the state. In total 75.7% of environmentally at-risk families enrolled in home visiting/family support programs. Child Protective Services served an additional 3.2% of families.

The second program component is an enabling service for those eligible families desiring home visits aimed at preventing child abuse and neglect by increasing family functioning, enhancing parent-child interactions, and supporting normal child development to promote safe, healthy, and happy children. On-site program specialists have been instrumental in provision of services, providing expertise in the areas of early identification of potential developmental delays under IDEA, Part C and supporting families with substance use, intimate partner violence, and mental health issues. Forty percent of families enrolled in FY 2003 experience current intimate partner abuse and/or substance use. Currently, the program serves a total of 4,675 children in 4,291 at-risk families.

- 98% of enrolled families have an identified medical home;
- 95.9% of children are developmentally age appropriate; and,
- 99% of children enrolled for at least twelve months had no confirmed reports of child abuse/neglect.

b. Current Activities

The objective for this measure is to increase participation 3-5% every year. Given recent performance, a more detailed data analysis will be conducted to inform policy and procedure. HHS has designed and implemented a quality improvement plan aimed at increasing rates of engagement and retention to improve program effectiveness. HHS has also re-engineered the training model to increase emphasis on risk factors and community-based/interagency coordination (CWS, PHN, EIS, WIC, Medicaid) of resources and services. HHS is also an active member of the MCHB Violence Prevention Workgroup.

c. Plan for the Coming Year

The objectives for this measure were set to meet a court-mandated benchmark of 90% as outlined in the Felix Consent Decree. The Decree was established to assure the State's progress to develop a system of care for children with special needs in accordance with the

Individuals with Disabilities Act (IDEA). The Hawaii Healthy Start program is part the State's system of early intervention services addressed by Part C of IDEA. For more information on the Felix Consent Decree see the State Overview narrative.

Healthy Start program data will be analyzed to determine why the objective is not being met.

In addition to continuing FY 2003 activities, future plans include supporting the DOH Maternal and Child Health Branch's restructuring efforts to expand services across the lifespan to address health disparities and continuity of services.

State Performance Measure 9: Degree to which the MCH agency performs ten essential public health functions, as measured on a scale from 0-30. [SPM 15]

a. Last Year's Accomplishments

This measure reflects the State priority to improve assessment and surveillance of MCH populations, including children with special health care needs and is based on a checklist of the 10 essential public health services for MCH. The 2003 score for this measure is 21. The objective of 17.9 was met. Data for this measure is a consensus score determined by the MCH agency's core staff composed of senior level management. The checklist is attached.

Training was provided to Title V agency staff in January 2002 on Capacity Assessment for State Title V (CAST-5), which has been adopted as the tool for measuring SPM #15 and for developing strategic direction for capacity building activities. This measure is related to Healthy People 2010 Objective 23-11: (Developmental) Increase the proportion of State and local public health agencies that meet national performance standards for essential public health services.

Improvements were made in the following areas:

- 1) Mobilize community partnerships to identify and address maternal and child health problems;
- 2) Provide leadership for priority setting, planning and policy development to support community efforts to assure the health of the MCH population;
- 3) Assure the capacity and competency of the public health and personal health workforce to effectively address MCH needs; and
- 4) Evaluate the effectiveness, accessibility, and quality of personal health and population-based MCH services.

Infrastructure building activities resulted in improvements in these four essential public health services. Mobilizing community partnerships is the strength of the Title V agency. Please refer to the agency coordination section of the Title V report for details.

Leadership was demonstrated in the initiation of the Title V needs assessment; by bringing stakeholders together to develop a comprehensive early childhood service system; and by facilitating and staffing a statewide Perinatal Consortium and Summit.

The public health workforce capacity has been enhanced through various local and national training sessions and conferences. Title V agency staff have attended a series of local data training modules provided by the Hawaii Outcomes Institute. Also, staff have enrolled in the MCH Certificate program offered by the University Department of Public Health Sciences and Epidemiology.

Evaluation of the effectiveness, accessibility and quality of MCH services continues to be a

challenge. Improvements were made in evaluation of accessibility. The Hawaii Uninsured Project held a stakeholders meeting to develop and evaluate strategies to provide health coverage for all people in the state. Purchase of service contracts to community based providers for uninsured individuals have improved access for this population. By increasing the number of health professional shortages and medically underserved areas, increased numbers of National Health Service Corps personnel have been successfully recruited to underserved areas of the state.

b. Current Activities

The CAST-5 training held in 2002 identified data capacity and communication skills as the priority need areas to assist the MCH agency in performing the 10 essential public health services. During the current year, the focus has been on infrastructure activities related to improving data capacity.

A Research and Advisory Committee (RAC) composed of Title V staff has been established to address the data capacity issues identified in the CAST-5 training. The group has completed a Title V database inventory and is conducting skill-building activities.

The PRAMS database is being analyzed and perinatal issues such as prematurity are being investigated. Results will be used for program planning and policy development.

An adolescent survey committee composed of Title V staff and partners implemented a strategy to coordinate the administration of four health surveys in the Department of Education during the school year. These include the Youth Risk Behavior Survey (YRBS), and Department of Health surveys on youth tobacco, substance use and nutrition. Regrettably, the new survey strategy did not yield the required response rates to secure weighted data for the YRBS and tobacco surveys. The Committee is evaluating and modifying the survey process to ensure weighted data is produced for the next survey period.

Title V staff is evaluating data that programs are requesting in several purchase-of-service (POS) contracts. A Title V research statistician is visiting POS contractors to evaluate data collection activities. The goal of this effort is to collect only data that is useful to contractors and for Title V planning. In collaboration with State Systems Development Initiative (SSDI) staff, a program planning model is being developed to determine which data elements should be collected from contractors.

The children with special health needs (CSHN) program is improving data capacity to achieve the national outcomes for CSHN. CSHN data from the national household survey has been disseminated to stakeholders and is being analyzed.

The State MCH Epidemiologist, with CSHNB, studied the demographic characteristics of infants who did not return for follow-up, and concluded that failure to complete the hearing screening follow-up may be related to cultural differences, which has implications for targeting screening efforts and resources. The study was published in Pediatrics, May 2003 Supplement.

SSDI activities have focused on data linkage in collaboration with the Office of Health Status Monitoring, CSHNB and the WIC program. Please see narrative on HSCI #9 for details.

As part of the Title V MCH needs assessment, an evaluation was conducted of existing priority needs. It was decided by the Title V Needs Assessment Steering Committee, that the priority to improve assessment and surveillance of MCH populations is no longer a priority since the focus on core public health services is now an integral part of the agency's work and is strongly supported by the DOH.

c. Plan for the Coming Year

In 2005, infrastructure building activities will focus on the priority areas of improving data capacity and communication skills, which will assist the Title V agency's performance of the 10 essential public health services. The performance objectives have been set to achieve 25 out of a total score of 30 by 2010.

The most important activity will be to address the following recommendation from the 2002 Title V Block Grant review: "In consultation with HRSA contact/identify key technical assistance needs around epidemiology and data interpretation, especially in regard to strategic planning for workforce development and staff capacity in terms of data analysis." This recommendation has been incorporated in Form 15, Technical Assistance Request. The Title V agency has access to a number of databases and the SSDI project will focus on obtaining electronic access to more databases and linking datasets. However, Title V staff needs technical assistance and training on data interpretation and epidemiology in order to access policy and program relevant information in a timely manner. Currently, the only two epidemiologists in the Title V agency are an MCH epidemiologist assigned by CDC and the epidemiologist for the Ho'opili Pono program. They both focus on the perinatal period. A great need exists to develop capacity around epidemiology and data interpretation for all staff involved in program and data.

Related to improving data capacity is the need to improve program evaluation capacity. Program evaluation has been included in Form 15 TA Request.

Activities described in the current year will continue in 2005. The Research and Advisory Committee (RAC), which is composed of research statisticians, data systems staff and epidemiologists will play a key role in improving data capacity. Collaboration of RAC members with program staff will be integrated in the technical assistance on data interpretation and epidemiology.

The second priority will be to expand the numbers of staff with communication skills. The following areas for improvement have been identified: 1) ability to translate data and other scientific/programmatic information for diverse audiences; 2) ability to design and produce high quality data-based reports and other information products; and 3) ability to communicate health information in a manner to inspire and motivate communities. The Title V agency has a communications officer who has been key to improving communication skills. Improvement of data capacity will be important in addressing the communication capacity needs described above.

The 5 year MCH needs assessment and plan of action will be completed in conjunction with state and community partners. Work on implementation and monitoring will begin.

State Performance Measure 10: Percent of children 0-3 yrs who are developmentally delayed/biologically/environmentally at risk who receive early intervention services as specified in their Individual Family Support Plan [SPM 16]

a. Last Year's Accomplishments

The 2003 federal child count identified 4,178 eligible children who received Early Intervention (EI) services, a decrease from the previous year due to contractual changes in the Hawaii Healthy Start (HHS) program. However, there was an increase in children served with developmental delays.

Early Intervention Section (EIS) is the lead agency responsible for the statewide, comprehensive, interagency system of early intervention services for infants/toddlers 0-3 years who are developmentally delayed or biologically/environmentally at risk. Services are mandated by Part C of Individuals with Disabilities Education Act (IDEA), Hawaii Statutes SS321-352, and Felix Consent Decree. The proportion of eligible children receiving (EI) services indicate the extent to which mandates are met and whether resources are adequate and sustained over time.

EI services include: assistive technology, audiology, family training, counseling, home visiting, health services, medical services (diagnostic/evaluation), nursing, occupational therapy, physical therapy, psychological, social work, special instruction, speech pathology, transportation, vision services. As appropriate, EI services are provided in natural environments, including home/community settings in which children without disabilities participate. Services are provided by EIS, HHS, and Public Health Nursing Branch (PHNB), through state and contracted programs, fee-for-service providers, and other community programs such as Early Head Start.

EIS is responsible for developing, maintaining, and improving components of the statewide EI system, including: a central directory of service providers, public awareness, child find, evaluation/assessment procedures, Individual Family Support Plan (IFSP), personnel standards, procedural safeguards, complaint resolution, interagency agreements, and data collection.

All eligible children received EI services. Factors contributing to temporary service gaps included staff vacancies, recruiting difficulties, increased travel time to serve children in natural environments, insufficient number of providers. Gaps were addressed by using fee-for-service providers and a transdisciplinary service approach. To increase resources, EIS requested additional funds and position upgrades to attract qualified/experienced applicants.

Medicaid/QUEST reimbursement for EI services is through a Memorandum of Agreement with the Dept. of Human Services. Other EIS programs include the Inclusion Project which provides tuition support for infants/toddlers with developmental delays to participate in child care. The Keiki Care Project provides technical assistance/training to preschool staff serving children 3-5 with behavioral challenges and their families. State Improvement Grant (Dept. of Education--DOE) funding is used to support training activities. The Hawaii Early Childhood Hearing Detection and Intervention Project supported services to infants/toddlers with hearing loss and their families.

b. Current Activities

EI services continue to be provided under Part C of IDEA.

The focus of training has been on IDEA Part C requirements as a result of federal monitoring. EIS has met its initial goal of ensuring that all EI staff (EIS, PHNB and Healthy Start) attends a 3-day training on the federal regulations, IFSP development and transition that was developed by EIS. EIS continues to support staff and families to attend other trainings and conferences (e.g. the annual Pac Rim conference for people with disabilities, their families, researchers and professionals and the SPIN-Special Parent Information Network- conference). Child care reimbursement is provided to support family attendance.

Public awareness activities include participation in health fairs and other community activities, brochures, newsletters, and information to pediatricians/family practitioners. Information is included in hospitals' birth packets. EIS is identifying underserved populations.

To continue Medicaid reimbursement for EI services, EIS is developing appropriate policies

and procedures necessary to meet Balanced Budget Act requirements.

EIS continues working with both DHS and DOH/Child and Adolescent Mental Health Division (CAMHD) on two separate projects that provide behavioral support for children 3-5 years with social, emotional or behavioral issues identified by behavioral assessments. Objectives include training families, care providers, and preschool staff to support child within the home, childcare setting or community preschool, and setting up environments to minimize disruptive behaviors. Four projects on the neighbor islands were funded through the DOH/CAMHD project.

EIS submitted its Improvement Plan Final Report to the federal Office of Special Education Programs (OSEP). This report on the State's progress in addressing areas of non-compliance with Part C/IDEA included monitoring contracted programs, evaluation in all 5 developmental areas, developing IFSP with all required content, and transition planning/implementation. All Part C providers (EIS, PHNB, Healthy Start) monitored their Part C programs and identified areas of need, which are now being addressed through programs' Improvement Plans.

To support increased numbers of children with developmental delays and to address OSEP's concerns, three Request for Proposals were disseminated and, as a result, there will be three new contracted EIS programs on Oahu; agencies on Oahu will provide multi-disciplinary comprehensive developmental evaluations; and an increased number of fee-for-service providers will be available to meet the needs of the Part C population.

EIS continue to investigate issues related to Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) requirements.

c. Plan for the Coming Year

Mandated EI services will continue to be provided under Part C of IDEA for infants and toddlers age 0-3 years who are developmentally delayed, biologically at risk, or environmentally at risk.

EIS will continue developing, maintaining, and improving components of the statewide EI system.

EIS will continue to provide and/or support training. Public awareness activities will continue.

EIS will continue its collaborative activities with DHS and DOE and identifying new agencies with which to work.

New programs will support the increased number of children with developmental delays. All children will receive a comprehensive developmental evaluation.

EIS will continue to work toward 100% compliance with IDEA Part C requirements. EIS will continue its on-going monitoring of all EI public and private programs. The program will address resource issues by monitoring and tracking the number of children served and expenses of EI providers, preparing Biennium Budget requests if needed, and evaluating options to address staffing problems for therapy and other positions.

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

1) Percent of women who report use of alcohol, tobacco, and other drugs during pregnancy. [SPM 3]				
1. Conducts the Pregnancy Risk Assessment Survey to collect data on substance use during pregnancy for use in needs assessment and program planning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Contracts to provide perinatal support services to high-risk pregnant women statewide.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Contracts to provide outreach and pretreatment services to substance abusing pregnant women.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provides culturally competent services to areas of high risk for infant mortality and morbidity.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Advocates for policies/programs that support treatment for drug-addicted mothers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provides training on smoking cessation interventions and substance use and parenting.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Targets smoking cessation messages to pregnant women.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Provides screening and referral for WIC low income perinatal clients who use substances.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Supports networking among programs that work with substance using families.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Implements action plans related to substance use and smoking identified at Perinatal Summit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Pyramid Level of Service			
STATE PERFORMANCE MEASURE	DHC	ES	PBS	IB
2) Percent of teenagers in grades 9 to 12 attending public schools who report smoking tobacco within the last 30 days. [SPM 5]				
1. Provide tobacco and substance abuse prevention education to students and community.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide support for community coalitions to conduct prevention awareness activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Plan and implement strategies to prevent youth substance use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide Media Literacy Training for public school teachers to address youth substance use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provide training and certification on Tobacco Cessation Interventions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide training to retail merchants on the law prohibiting tobacco sales to minors.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Monitor and enforce law prohibiting tobacco sales to minors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Improve inter-agency collaboration to build infrastructure needed to support and sustain the Coordinated School Health Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Develop infrastructure for prevention resource coordination.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Improve surveillance systems through inter-agency planning efforts to administer 4 school health surveys that collect student health data used for needs assessment and program planning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Pyramid Level of Service			

STATE PERFORMANCE MEASURE	DHC	ES	PBS	IB
3) Rate of confirmed child abuse/neglect reports per 1,000 for children aged 0-5 years. [SPM 7]				
1. Conducts screening of all civilian hospital births for risk factors of child abuse and neglect.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provides home-visiting services to families at risk for child abuse & neglect.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Contracts to provide family support and development services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Contracts to provide outreach and pretreatment services to substance abusing pregnant women.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Administers Children's Trust Fund to provide grants for family support programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Contracts to provide statewide hotline for parents who have questions about parenting.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Assures violence prevention is integrated into all Title V service programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Participates on community coalitions and councils dedicated to child and family well being.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Compile and analyze child and family violence data for use in needs assessment and program planning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Work with state/community partners to identify priority issues concerning family violence and develop plan to address them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Percent of teenagers in grades 9 to 12 attending public schools who report being involved in a physical fight within the last 12 months. [SPM 8]				
1. Provide violence prevention education including sexual assault to students and community.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Contract to provide sex assault prevention education and trainings through the Sex Assault Treatment Center.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Improve inter-agency collaboration to build infrastructure needed to support and sustain the Coordinated School Health Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Improve surveillance systems through inter-agency planning efforts to administer 4 school health surveys that collect student health data used for needs assessment and program planning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

5) Percent of pregnancies (live births, fetal deaths, abortions) that are unintended. [SPM 11]				
1. Contracts to provide family planning services to uninsured women statewide.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Contracts to provide reproductive health education targeting at-risk populations.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Conducts campaign to promote Emergency Contraception through education and advocacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Builds capacity for data collection system used to monitor provider contracts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Conducts the Pregnancy Risk Assessment Survey (PRAMS) to collect data on unintended pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Analyzes and disseminates PRAMS data for program planning and policy development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pyramid Level of Service			
STATE PERFORMANCE MEASURE	DHC	ES	PBS	IB
6) Percent of infants with hearing loss who are receiving appropriate intervention services by age 6 months. [SPM 12]				
1. Inform families of infants w/ hearing loss about audiological evaluation and early intervention.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Assist families in arranging needed audiological evaluations and transportation support.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At family request, refer infants with permanent hearing loss for early intervention services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide consultation to early intervention staff on treatment planning for infants with hearing loss.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Develop lending libraries with videos and other materials on management and other aspects of hearing loss.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Pilot a Deaf Mentor Program on Oahu and monitor for developmental impact and family satisfaction.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Collaborate with other community deaf education services for families of infants with hearing loss.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Provide workshops and training to improve understanding of hearing loss and early intervention/other services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Monitor and track audiological evaluation results, hearing, amplification, and early intervention enrollment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Research study of service history and developmental status of children with congenital hearing loss.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Pyramid Level of Service			
STATE PERFORMANCE MEASURE	DHC	ES	PBS	IB
7) Percent of teenagers in grades 9 to 12 attending public				

schools that are overweight. [SPM 13]				
1. Improve inter-agency collaboration to build infrastructure needed to support and sustain the Coordinated School Health Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collects nutrition and weight data for pre-adolescent school children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collects weight data on WIC low income children as part of national nutrition surveillance system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provides nutrition counseling and food coupons to low income families with young children.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Supports community based organizations to plan and conduct health promotion events.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Assure nutrition and physical activity promotion is integrated into MCH programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Promote improved nutrition efforts through the 5-A-Day Coalition.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Promotes healthy lifestyles through public education campaigns.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The percent of families assessed to be at risk for child maltreatment that enroll in Hawai'i Healthy Start home visiting support services. [SPM 14]				
1. Identify at-risk families.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Refer environmentally at-risk families to program services, including home visiting services from Healthy Start.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Monitor Healthy Start families for potential child abuse, neglect and other health issues.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Conduct developmental screens.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Refer children with suspected developmental delays for professional evaluation.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Provide case management, including resource and referral information, follow-up, and transition.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Connect families to a medical home to assure regular source of medical care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Increase family functioning via positive parent-child interaction.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Inform parents about normal child development.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Support parents at high-risk from substance abuse, family violence, and mental health issues via consultation, referral, follow-up.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Degree to which the MCH agency performs ten essential public health functions, as measured on a scale from 0-30. [SPM 15]				
1. Obtaining technical assistance and training to improve staff data collection and analysis skills.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. Development and enhancement of surveillance systems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Obtaining technical assistance and training to improve staff communication skills.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Mobilizing partnerships to identify and solve MCH problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Conduct MCH needs assessment in partnership with community stakeholders.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) Percent of children 0-3 yrs who are developmentally delayed/biologically/environmentally at risk who receive early intervention services as specified in their Individual Family Support Plan [SPM 16]				
1. Provide central point of contact and link to early intervention services (H-KISS hotline).	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide/contract for early intervention services for children 0-3 with developmental delays or biologically/environmentally at risk.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide training and support for families and service providers of children 0-5 with developmental delays or biologically/environmentally at risk, including challenging behavior.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide respite services for children with developmental delays (0-3 years) or serious/chronic illness (0-20).	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Increase public awareness about the availability of services through brochures, newsletters, and information at community events.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide and/or support training on IDEA Part C, State Plan, IFSP, transition, inclusion, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Assure quality of service provision through internal quality assurance plan, program monitoring, and internal service testing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Implement federal Office of Special Education Programs (OSEP) approved improvement plan to be in compliance with Part C of IDEA.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Monitor and evaluate resources and needs through tracking services, staffing, funding/expenses, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Assess and assure early intervention services meet the increased number of children and service needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

E. OTHER PROGRAM ACTIVITIES

PRESCHOOL DEVELOPMENTAL SCREENING PROGRAM

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. Early intervention is stressed to prevent the development of secondary problems and for best child outcomes. PDSP trains community resources in standardized

screening for children in their care. PDSP provides consultation and facilitates follow-up services, including counseling on intervention strategies, referral to the Department of Education for special education services, evaluation for children who are not eligible for other services, referral to various community resources, and monitoring.

GENETICS PROGRAM

Genetics Program plans, develops, and implements statewide genetics activities in coordination with other public/private organizations; assesses genetic needs in the community 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. It has 2 projects funded by the MCH Bureau/Genetic Services Branch. The "Genetic Awareness, Implementation and Data" project addresses the need to improve public health genetics and raise awareness in Hawaii. Activities include providing education to physicians, public health professionals, consumers, and policy makers; and incorporating genetics education into public health programs. The "Newborn Screening using Tandem Mass Spectrometry: Financial, Ethical, Legal, and Social Issues" project is using a collaborative multi-state effort to address issues associated with newborn metabolic screening and incorporation of new technologies.

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 800-1,000 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 currently funded by the Centers for Disease Control and Prevention and special funds from \$10 of each marriage license fee. It is now established in the DOH, through Act 252 of the 2002 State Legislature.

HEALTHY CHILD CARE HAWAII (HCCH), funded by the MCH Bureau, is a collaborative project of FHSD/CSHNB, University of Hawaii Department of Pediatrics, and American Academy of Pediatrics-Hawaii Chapter. The project promotes the health and safety of young children in child care. Activities include: recruit, train, and connect health consultants to child care programs; train pediatric residents in recognizing and promoting quality child care; provide information to child care providers, health consultants, and other agencies/programs on national health and safety performance standards, medical home, and health insurance; and integrate the HCCH areas of performance standards, health consultation, and access to health insurance and medical homes into Hawaii's Early Childhood Comprehensive Systems plan.

//2005/ Additional funding support is being provided by the Department of Human Services.//2005//

DOMESTIC VIOLENCE/MENTAL ILLNESS/OTHER SPECIAL POPULATIONS

The need for a coordinated and comprehensive systems approach to Domestic Violence remains a community need. The Perinatal Consortium in conjunction with the MCHB formed a committee to address the specific needs of pregnant and post-partum women with respect to domestic violence. DV data is being compiled from service contracts and PRAMS. MCHB will seek other funding opportunities and will explore ways to better utilize current resources to coordinate the response system for these women.

LEAD POISONING SURVEILLANCE

The Childhood Lead Poisoning Prevention Program (CLPPP), funded through the Centers for Disease Control, provides surveillance and prevention activities to decrease the incidence of childhood lead poisoning. Hawai'i has a blood lead poisoning rate of about 2%, which is comparable to the national average of 2.2%. About 10,000 children are screened a year, most covered by the Med-QUEST program; thus CLPPP continues to work with Med-QUEST to increase the screening rates and improve case management. CLPPP collaborates with many partners to plan and develop

policy. Educational outreach efforts include presentations to MCH programs, public service announcements on television as well as printed materials.

//2005/ The CDC grant was not renewed, but CLPPP continues to provide limited surveillance and prevention activities with existing state resources. Prevention/intervention guidelines to address child lead poisoning are being drafted for distribution to health professionals and community based agencies that have responsibility to prevent lead poisoning. //2005//

SAFE SLEEP HAWAII

Safe Sleep Hawai'i '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.

THE PARENT LINE

The Parent Line is a free, statewide telephone warm line that provides support, encouragement, informal counseling, information, and referral to callers. Half of the callers are considered at high risk for family disintegration, child abuse and neglect, and children's social, emotional, or behavioral problems. A majority of the calls involve children aged birth to 5. The callers receive information and support about a wide variety of child behaviors, child development issues, community resources, and solid parenting skill building. Usually, these families have not accessed any other services; and this phone call is their initial entry to service providers.

F. TECHNICAL ASSISTANCE

See Form 15 for technical assistance request and discussion in narrative for State Performance Measure 15 focused on building core public health capacity for the Title V agency.

V. BUDGET NARRATIVE

A. EXPENDITURES

SIGNIFICANT BUDGET VARIATIONS - FORM 3 (FISCAL YEAR 2002)

The total Title V Block Grant amount awarded to the State in fiscal year 2002 was \$2,250,648. Out of this total grant award, a sum of only \$615,618 was expended in federal fiscal year 2002 due to carryovers from fiscal year 2001. The total amount of State funds expended in fiscal year 2002 was \$5,024,175 more than the budgeted amount of \$37,453,817. This was due in part to additional appropriations for the Healthy Start Program (\$4,582,213) which was not reflected in the fiscal year 2002 budget and collective bargaining costs. Actual expenditures for program income was \$4,619,969 less than the budgeted amount because of a significant backlog in reimbursement from Medicaid for the Healthy Start and Early Intervention Programs.

SIGNIFICANT BUDGET VARIATIONS - FORM 4 (FISCAL YEAR 2002)

In fiscal year 2002, the State expended \$3,726,160 more than what was budgeted for in the category "Children 1-22 years old" because of additional appropriations for the Healthy Start Program as mentioned in the previous section. Conversely, the category "Children with Special Needs" expended \$4,203,768 less than what was budgeted for in that category because of a significant backlog in reimbursements from Medicaid for the Healthy Start and Early Intervention Programs. The State expended \$510,699 less in fiscal year 2002 for the category "Administration" due to the State's imposition of a spending restriction on a \$500,000 grant to the Wahiawa General Hospital for uncompensated and charity care.

SIGNIFICANT BUDGET VARIATIONS - FORM 5 (FISCAL YEAR 2002)

For the category "Direct Health Care Services," expenditures amounted to \$1,815,035 less than the budgeted amount in fiscal year 2002. The primary reason for this was that although \$2,339,250 was budgeted for the early intervention special fund under the "CSHCN" category, only \$292,350 was actually expended because of a significant backlog in reimbursements from Medicaid for the Healthy Start and Early Intervention Programs.

Under the category "Population Based Services," expenditures amounted to \$1,263,167 more than the budgeted amount in fiscal year 2002. This situation was due to the additional appropriations made for the Healthy Start Program under this category which was not reflected in the fiscal year 2002 budget.

Expended amounts for the category "Infrastructure Building Services" was \$1,435,379 less than budgeted for in fiscal year 2002 because the Title V budget was based on the fiscal year 2001 unobligated balance plus the fiscal year 2002 grant award which was much higher than actual personnel costs for this time period.

/2005/ Significant Budget Variations - Form 3 (Fiscal Year 2003) The total Title V Block Grant amount awarded to the State in fiscal year 2003 was \$2,281,433. Out of this total grant award, a sum of only \$550,315 was expended in federal fiscal year 2003 due to carryovers from fiscal year 2002. Actual expenditures for the category "Unobligated Balances" (\$1,743,398) was higher than the budgeted amount of \$1,392,603 used for the FY 2003 Title V application. (The unobligated balance was underestimated for the FY 2003 Title V application.) Actual expenditures in the category "State Funds" was \$231,646 more than the budgeted amount primarily due to a supplemental budget appropriation by the legislature for primary care services which was not anticipated during the preparation of the Title V application. The actual expenditures for the category "Program Income" was \$3,469,972 less than the budgeted amount because of a significant backlog in reimbursements from Medicaid for the Healthy Start and Early Intervention Programs. There were five new federal grants which were expended during fiscal year 2003, thus expenditures for the category "Other Federal Funds" was \$1,487,014 more than the budgeted amount.

SIGNIFICANT BUDGET VARIATIONS - FORM 4 (FISCAL YEAR 2003)

In fiscal year 2003, the State expended \$1,674,789 less than what was budgeted for in the category "Infants <1 Year Old" because both the Healthy Start Program and the Newborn Metabolic Screening Program did not fully expend their budgeted allocations. The State also expended \$957,462 less than what was budgeted for in the category "Children 1 to 22 Years Old" because the proportion of funding for the Healthy Start program which was budgeted under this category was not fully expended. The category "Children with Special Healthcare Needs" expended \$2,519,791 less than what was budgeted for because of a significant backlog in reimbursements from Medicaid for the Healthy Start and Early Intervention Programs. The State expended \$1,255,400 more than what was budgeted for in the category "Others" largely due to the following programs receiving appropriations after the fiscal year 2003 grant application had been submitted: a) supplemental budget appropriation for primary care services of which \$550,000 was expended for under this category and b) expenditures of \$358,162 for The Robert Wood Johnson Foundation grant (Hawaii Uninsured Project). Finally, the State expenditures were \$960,808 less than what was budgeted for under the category "Administration" due largely in part to: a) the State's imposition of a spending restriction for Wahiawa General Hospital for uncompensated and charity care; and b) Title V expenditures were less than what was budgeted for in this category.

SIGNIFICANT BUDGET VARIATIONS - FORM 5 (FISCAL YEAR 2003)

For the category "Direct Health Care Services," expenditures amounted to \$827,331 more than the budgeted amount in fiscal year 2003. The primary reason for this increase in expenditures was that the legislature appropriated State Rainy Day funds for primary care services in the fiscal year 2003 supplemental budget which was not reflected in the application budget.

The State expended \$2,959,823 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.

Under the category "Population Based Services," expenditures amounted to \$1,209,624 less than the budgeted amounts for fiscal year 2003 because both the Healthy Start Program and the Newborn Metabolic Screening Program did not fully expend their budgeted allocations.

Expended amounts for the category "Infrastructure Building Services" was \$1,281,273 less than what was budgeted for in fiscal year 2003. As a whole, the State's expenditures were less than what was budgeted for in fiscal year 2003 and this is reflective of the amounts expended for "Infrastructure Building Services." //2005//

B. BUDGET

The State's maintenance of effort level from 1989 is \$11,910,549 and the State's overmatch in fiscal year 2004 is \$32,801,527. There is no continuation funding for special projects or special consolidated projects in fiscal year 2004.

SIGNIFICANT BUDGET VARIATIONS - FORM 3 (FISCAL YEAR 2004)

The projected carryover from the fiscal year 2003 grant award to fiscal year 2004 is \$1,196,537. The carryover funds will be used to fund positions within the Family Health Services Division which primarily provides 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 insure that there would be adequate funds to cover payroll costs for new positions that were needed and to fund annual increases in the fringe benefit and collective bargaining rates for existing employees. Hypothetically speaking, if the entire grant award for fiscal year 2004 were to be expended in the first

year of the project period, the Division could face the possibility of a reduction in force within a year or two thereafter. The reason for this is that while the amount of the grant award has been relatively stable for the past several years, there have been increases in costs due to the establishment of new positions, as well as increases in the fringe benefit and collective bargaining rates for existing employees. For reasons cited above, it would be prudent for the Division to maintain a conservative approach in the expenditure of funds under this grant.

There has been a significant reduction of \$10,029,832 in State funds from fiscal year 2003 to fiscal year 2004 for several reasons. First, a sum of \$5,336,023 in State funds for the Healthy Start Program has been shifted to the State's Tobacco Settlement Special Fund and is now budgeted under the "Other Funds" category for this grant application. Secondly, the State funded subsidies for rural hospitals and the Sexual Assault Program (\$3,800,000) has been shifted to the State's Rainy Day Special Fund and is now budgeted in the "Other Funds" category for this grant application. Finally, other Special Funded Programs such as the Child Death Review Program, and Domestic Violence Prevention Program have been reclassified from State funds to "Other Funds." The budget for "Program Income" has been reduced by \$2,227,237 from fiscal year 2003 to fiscal year 2004 to reflect projected revenues.

SIGNIFICANT BUDGET VARIATIONS - FORM 4 (FISCAL YEAR 2004)

There was a decrease of \$938,881 from fiscal year 2003 to fiscal year 2004 in the category "Administration." The major reasons for this decrease was the elimination of two large grants in the administration budget -- Uncompensated and charity care for Wahiawa General Hospital for \$500,000 and the mobile dental clinic program for the Roman Catholic Church of Hawaii for \$100,000.

SIGNIFICANT BUDGET VARIATIONS - FORM 5 (FISCAL YEAR 2004)

There were no significant budget variations between fiscal years 2003 and 2004.

/2005/ The State's maintenance of effort level from 1989 is \$11,910,549 and the State's overmatch in fiscal year 2005 is \$33,565,911. There is no continuation funding for special projects or special consolidated projects in fiscal year 2005.

SIGNIFICANT BUDGET VARIATIONS - FORM 3 (FISCAL YEAR 2005)

The "Federal Allocation" category for fiscal year 2005 amounts to \$2,392,416. This figure is based on last year's grant award. Although HRSA provided the State with an estimated grant award amount of \$2,431,600 in June of 2004, the budget for the application had already been prepared utilizing last year's grant award as the basis for the anticipated award in fiscal year 2005.

The category "Unobligated Balance" amounts to \$1,405,951 in fiscal year 2004. The unobligated balance 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 insure that there would be adequate funds to cover payroll costs for new positions that were needed and to fund annual increases in the fringe benefit and collective bargaining rates for existing employees.

There has been a decrease of \$1,747,318 in the category "State Funds" from fiscal year 2004 to fiscal year 2005 primarily due to a \$2,092,518 legislative reduction for the Healthy Start Program. There has been a \$2,367,445 increase in the "Other Funds" category from fiscal year 2004 to fiscal year 2005 due to a \$2,200,000 supplemental budget appropriation made by the legislature for primary care services to uninsured individuals from the State's Rainy Day Fund. There are a number of federal grants which have terminated as of fiscal year 2004, thus resulting in a reduction of approximately \$916,962 in the "Other Federal Funds" category in fiscal year 2005.

SIGNIFICANT BUDGET VARIATIONS - FORM 4 (FISCAL YEAR 2005)

There was a decrease of \$1,297,373 from fiscal year 2004 to fiscal year 2005 in the category "Infants < 1 year old." The reason for this decrease was a legislative reduction in funding for the Healthy Start Program in fiscal year 2005. There was an increase of \$1,602,562 in the category "Others" primarily due to the inclusion of a \$2,200,000 supplemental budget appropriation by the legislature for primary care services in fiscal year 2005 and a concurrent reduction of funding for other programs under this category. An increase of \$307,077 under the category "Administration" from fiscal year 2004 to fiscal year 2005 is due to the inclusion of three neighbor island District Health Office nurse positions and clerical staff into the budget.

SIGNIFICANT BUDGET VARIATIONS - FORM 5 (FISCAL YEAR 2005)

The amount budgeted for the category "Direct Health Care Services" reflects an increase of \$2,456,224 from fiscal year 2004 to fiscal year 2005. This is largely due to a supplemental budget appropriation by the legislature of \$2,200,000 for primary care services to uninsured individuals from the State's Rainy Day Fund in fiscal year 2005.

There is a decrease of \$2,493,451 for the category "Population-Based Services" from fiscal year 2004 to fiscal year 2005. This is due largely in part to the legislative reduction of \$2,092,518 for the Healthy Start Program in fiscal year 2005.

Finally, the category "Infrastructure Building Services" reflects an increase of \$1,305,594 from fiscal year 2004 to fiscal year 2005. The reasons for this increase include: a) the Healthy Start Program designating a greater percentage of it's budget to this category; b) a significant increase in State funds for the Early Intervention Program which substantially increased this category; a) a shifting of categories for The Robert Wood Johnson Foundation Grant (Hawaii Uninsured Project) from "Population-Based Services" to "Infrastructure Building Services." //2005//

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.