REPORT TO THE TWENTY-FOURTH LEGISLATURE
STATE OF HAWAII
2007

PURSUANT TO ACT 178, SECTION 23, SLH 2005, AS AMENDED BY
ACT 160, SECTION 23.1, SLH 2006
REGARDING A REPORT ON
THE COST EFFECTIVENESS AND EFFICACY OF
THE HEALTHY START PROGRAM
FOR FY 2006-07

Prepared by

State of Hawaii
Department of Health
Health Resources Administration
Family Health Services Division
Maternal and Child Health Branch
December 2006

(33) By adding a new section to read as follows:

FHSD "SECTION 23.1. Provided that the healthy start program (HTH 550) shall continue to retool its program to improve its delivery of services; provided that the program shall prepare a report on the cost effectiveness and efficacy of its program for fiscal year 2006-2007; provided further that the report shall include a comprehensive plan that shall address but not be limited to the following information:

(1) A detailed accounting of improvements made to the healthy start program with regard to its delivery of services for home visits, specific steps taken by the program to retool, and any progress made by the program in its efforts to re-evaluate current delivery of services;

(2) An evaluation of the development of standards and protocols for model efficacy and cost effectiveness;

(3) Corrective action to improve the inconsistent program implementation cited by the Johns Hopkins University and appropriate measures to retool with regard to healthy start providers deviating from the program model;

(4) Development and implementation of new billing policies and procedures that best reflect accurate program costs and best practices; and

(5) Findings and recommendations made by the healthy start advisory task force and steps taken by the healthy start program to implement the healthy start advisory task force's recommendations regarding its restructuring and priority re-design issues;

and provided further that the healthy start program shall submit a status and progress report to the legislature no later than twenty days prior to the convening of the 2007 regular session."

(34) By adding a new section to read as follows:

"SECTION 29.1. Provided that of the special fund appropriation for the family health services division, health resources administration (HTH 595), the sum of $2,000,000, or so much thereof as may be necessary, from the early intervention special fund for fiscal year 2006-2007 shall be expended for the early intervention services program." FHSD

(35) By adding a new section to read as follows:

"SECTION 29.2. Provided that of the special fund appropriation for the family health services division, health resources administration (HTH 595), the sum of $2,400,000, or so much thereof as may be necessary, from the early intervention special fund for fiscal year 2006-2007 shall be expended for the healthy start program." FHSD

EXECUTIVE SUMMARY

The Hawaii Healthy Start Program is a statewide, voluntary home visiting program that strengthens families and prevents child abuse; promotes positive parent-child relationships; and monitors development. This Report to the Legislature includes information about program effectiveness, corrective action taken in response to results of previous evaluations, changes made to the Healthy Start billing system and summarizes the work of the Healthy Start Task Force. Included in this Report's discussion are the following topics:

1. Improvements made to the Healthy Start Program

    a. Individualized Family Service Plan (IFSP) refocused to address family risk factors
    b. Child Development Specialist Model revised
    c. Clinical Specialist Model revised
    d. Level System revised

2. Evaluation of Model Efficacy and Cost Effectiveness

    a. Model Efficacy to prevent Child Abuse and Neglect–99.65% of families enrolled in Healthy Start for 12 months had NO confirmed child abuse/neglect
    b. Level System as part of Model Efficacy–demonstrated progress in family risk factor reduction
    c. The Program continues to monitor all Program sites for compliance with the Office of Special Education Programs (OSEP) of the U.S. Department of Education
    d. Child Development screenings conducted by the Program demonstrate the Program's efficacy in identifying developmental delays and concerns at the earliest stages of a child's development
    e. The Program's rates for immunization (76%), establishing a medical home for each child (95.9%), and referring children and families to appropriate community resources are positive and demonstrate program efficacy
    f. The Program has partnered with Johns Hopkins University (JHU) and the Centers for Disease Control and Prevention (CDC) to pilot new protocols for home visitors
    g. The Program utilizes an accounting software system that allow timelier, more efficient, and more accurate reporting of financial information
    h. The Program will be utilizing a Family Survey to determine family satisfaction with Individuals with Disabilities Education Act (IDEA), Part C programs which is required by OSEP with results that should be available February, 2007
    i. The Program will continue on-site monitoring visits, identify training issues, and will be collaborating with Hawaii Family Support Institute for additional training opportunities and to partner with other community resources which serve the same communities that Healthy Start serves

3. Corrective Actions Taken per the JHU Study

    a. Provided training and technical assistance to purchase of service (POS) providers for ISFP development
    b. Revised and realigned current models for clinical services
    c. Partnered with JHU and CDC for home visiting protocol
    d. Developed community collaborative relationships
    e. Met regularly with POS providers to address team building and staff turnovers

4. Development and Implementation of New Billing Policies

    a. Conducted a time study and expenditure report review in May, 2006
    b. Revised the billing formula and billing procedures
    c. Anticipate current Healthy Start contracts will be terminated and a new Request for Proposals (RFP) will be issued to reflect the new billing revisions

5. Implementation of Advisory Task Force Recommendations

    a. Anticipate that with the new RFPs, recommended program model changes (from the Task Force) may be implemented with a new contract period
    b. Task Force recommendations are detailed in a separate report

Report to the Legislature Pursuant to Section 23.1 of Act 178/05, as amended by Act 160/06

Introduction

The Hawaii Healthy Start Program is a statewide, voluntary home visiting program that strengthens families and prevents child abuse; promotes positive parent-child relationships; and monitors child development. It consists of two components – Early Identification and Home Visiting. The Early Identification component provides screenings and assessments to identify prenatal women and families at-risk for sub-optimal health, developmental delay, and maltreatment. The Home Visiting component provides support services within the family's natural environment to reduce the likelihood of child maltreatment by reducing parental or environmental stressors. Home Visiting services are offered until the child reaches three years of age or five years if there is a younger sibling.

Hawaii Healthy Start utilizes a paraprofessional model. Home visitors are trained paraprofessionals working with a team consisting of a clinical supervisor, clinical specialist, and child developmental specialist. Home visiting services include, but are not limited to, screenings for possible developmental delays and referrals for early intervention services; teaching the care giver about child development, positive parenting skills and problem solving techniques; linking to community resources; and, when necessary, encouraging professional help for substance abuse, maternal depression, and domestic violence.

The initial assessment of a family usually occurs in the hospital following the child's birth. Mothers and fathers are assessed using the Kempe Family Stress Checklist. The checklist assesses 10 risk factors, and is scored (0 for Normal, 5 for Mild, or 10 for Severe) on the following factors:

1 - Parent Beaten or Deprived as Child
2 - Parent with Criminal/Mental Illness/Substance Abuse
3 - Parent Suspected of Abuse in the Past
4 - Low Self-Esteem, Social Isolation, Depression, No Lifelines
5 - Multiple Crises or Stresses
6 - Violent Temper Outburst
7 - Rigid and Unrealistic Expectations of Child
8 - Harsh Punishment of Child
9 - Child Difficult and/or Provocative as Perceived by Parents
#10 - Child Unwanted or At Risk for Poor Bonding

Items # 4, 5, 6, and 8 are considered changeable or malleable, and are the environmental risk factors that home visiting programs focus on to reduce child maltreatment.

In November 2005, the Enhanced Healthy Start (EHS) program, which was a Department of Human Services (DHS) secondary purchase on a Department of Health (DOH) Request for Proposals (RFP) for Healthy Start Services, was initiated statewide.

Referrals by Child Welfare Services (CWS) and purchase of service (POS) providers of Family Strengthening Services (FSS) and Voluntary Case Management (VCM) are mandatory for families with children up to one year of age and are optional for families with children 1 year to 30 months of age. Providers may move families with greater needs from the regular (or basic) Healthy Start program to the Enhanced Program on a space available basis and may move families needing less

intense service (e.g. closed CWS cases) to regular Healthy Start. The Enhanced Program is currently funded and administered by the DHS, but is attached to each regular Healthy Start program. The program is "enhanced" by the additional support of a nurse and certified substance abuse counselor.

Response to Section 23.1

This report will address the following as requested under Section 23.1:

1. **A detailed accounting of improvements made to the Healthy Start program with regard to its delivery of services for home visits, specific steps taken by the program to retool, and any progress made by the program in its effort to re-evaluate current delivery of services**

   Improvement activities described in this report may be closely aligned with some of the recommendations for change described in the Healthy Start Advisory Task Force Report in response to Senate Concurrent Resolution 227. The Task Force initially proposed recommendations for change as either "Change Now", "Requires contract modification", or "Requires new request for Proposal". The following improvement activities were from the "Change Now" list developed by the Task Force and from program changes initiated by the Maternal and Child Health Branch (MCHB) as a result of program monitoring.

   a. *Individualized Family Service Plan (IFSP) reinforced* – This improvement activity was implemented following on-site visits from the U.S. Department of Education, Office of Special Education Programs (OSEP). Monitoring by MCHB staff revealed that IFSPs were written and implemented with a heavy emphasis on child development goals rather than family risk factor reduction. Previous reports to the legislature have outlined reasons for this movement away from fidelity to the Healthy Start program model, the most obvious being the program's inclusion under the Individuals with Disabilities Education Act's (IDEA) Part C which mandated numerous regulatory requirements with specific emphasis on child related goals and objectives. Refocusing programs back to the Healthy Start mission of reducing family stress risk factors in addition to meeting compliance requirements for OSEP has been the major impetus for retooling the program. Close collaboration with the POS provider for training and technical assistance (The Institute for Family Enrichment) has yielded the development of a curriculum to assist Family Support Workers to use the initial assessment information, and to strategically and effectively address those risk factors during their home visits. Continued education on the IFSP and support to the Family Support Worker regarding risk factor discussion with the family will be an ongoing challenge, but are crucial to retooling Healthy Start to closer fidelity to its model.

   b. *Child Development Specialist Model revised* – Program improvement activities included streamlining the Child Development Specialist's services to allow for more flexibility and options to be more responsive to the specific communities which programs serve. Prior to the model revision, the Child Development Specialist reviewed records for *potential* red flag concerns based on the initial Family Stress Checklist assessment (scores of 10 or more on Family Stress Checklist items 1, 3, 7, 8, 9, 10). With the model revisions, the Child Development Specialist can now focus on supporting the Family Support Worker in

on-going child assessment and development activities in the family home and can individualize services based on the Family Support Worker's observations of parent-child interactions and the family's needs (see Attachment A). By streamlining these requirements, the Child Development Specialist's expertise is utilized more efficiently and effectively. The Child Development Specialist is a program resource for Family Support Workers and families, which directly affect compliance with OSEP requirements.

c. *Clinical Specialist Model revised* – Revision to this model also allowed more flexibility and responsiveness to individual family and community needs. The original model required the Clinical Specialist to review all assessments with a Family Stress Checklist score of 50 or more, and to write a clinical plan for the family even before a face to face meeting. With the new model changes, the Clinical Specialist is able to provide consultation and actual treatment to families after their initial engagement by the Family Support Worker. This allows for better services to families and easier entry into the family, thereby encouraging better follow through with possible clinical referrals for substance abuse, domestic violence and mental health treatment (see Attachment B).

d. *Level System revised* – The Level System is a Healthy Families America (HFA) credentialing requirement for home visiting programs. The requirement stipulates that a home visiting program must have well defined criteria for increasing or decreasing intensity of services. Based on research and supporting literature, HFA recommends that home visits occur on a weekly basis for at least the first 6 months following the birth of a baby (Powell and Grantham-McGregor, 1989). The Hawaii Healthy Start Level Movement System determined that movement through this system would demonstrate a family's progress with Healthy Start program goals. The system also dictated that as a family moved through levels (1-4), they had to meet stringent external requirements and could only progress through the levels on a sequential basis.

The system is being revised to redefine program intensity as the family's needs for services based on assessment scores. Assessment scores are to be derived from the initial identification assessment (Kempe Family Stress Checklist) and the family's availability to accommodate a home visitor. In keeping with HFA requirements, every family would be initially encouraged to participate in the Hawaii Healthy Start program on a weekly home visiting schedule. However, realistically there are some families who do not want a weekly visit and therefore, never engage in the program or disengage shortly after beginning home visiting services because of the stringent requirements. Because of its voluntary nature, HFA requires outreach services for a 3 month period to maximize engagement. The revised Level System recognizes and requires the Family Support Worker to openly discuss the family's risk factors which should easily translate into an open discussion of goals and objectives on an IFSP. This discussion which will focus on those four malleable risk factors (FSC #4, 5, 6, 8) and will occur every 6 months at every IFSP meeting. Movement through the revised Level System will be described using frequency descriptors (e.g. weekly, bi-monthly, monthly, quarterly, outreach) . Logically one would expect that the family's frequency of home visits would correlate with the intensity of risk factors occurring in the home. However, because the family's preference is factored into the formula, this may not always correlate. Nevertheless, this new system mandates that the Family Support Worker continuously focuses on those malleable risk factors initially identified for each family. Therefore, families served by the Hawaii Healthy

Start program would be "progressing" based on changes in specific risk factors identified as risks for child maltreatment.

In summary, the improvement activities to the actual program model which affect service delivery to the community have encompassed streamlining procedures and documentation requirements for the Child Development Specialist and Clinical Specialist, allowing workers more flexibility to be responsive to the family and particular community needs, and making significant changes to the program model in order to move closer to the original mission of Hawaii Healthy Start - reducing family risk factors for child maltreatment. These streamlining activities allow for better utilization of limited professional components to the home visiting model. The larger model changes require extensive and continuous education and support, as they are the cornerstones to reinforcing fidelity to the original Healthy Start home visiting model.

2. An evaluation of the development of standards and protocols for model efficacy and cost effectiveness

a. Model Efficacy to prevent Child Abuse and Neglect – Program efficacy is illustrated by numbers of at risk children and their families enrolled in the program for at least 12 months with no confirmed report for child abuse and neglect, and EHS families with no re-occurrence of child abuse and neglect. Before reviewing occurrence data, it is meaningful to look at the level of acuity or seriousness of risk factors among families enrolled in the program.

Table 1: Family Stress Checklist scores for families enrolled in FYs 04, 05 and 06

Score Category	FY04 Count	FY05 Count	FY06 Count
No Record	54	27	16
0 – 25	409	513	737
30 – 40	2,020	2,115	2,029
45 – 55	1,327	1,228	1,118
60 – 70	323	298	287
75 +	12	14	11
Total:	**4,145**	**4,195**	**4,198**

CHEIRS back end data - June 30, 2006

Table 1 illustrates the number of families who scored at least a 30 on the Kempe Family Stress Checklist, and accepted home visiting services from Hawaii Healthy Start for fiscal years 2004, 2005, and 2006. Those families with scores below the program cut off of 30 were enrolled due to a "clinically positive" assessment; or the family could have been previously screened (prior to 2004) and had a subsequent child and the family continued enrollment in the program without a new assessment being conducted.

Families whose Kempe Family Stress Checklist scores are over 45 are at higher risk for CWS involvement for multiple risk factors which include substance abuse, mental health

and domestic violence. The acuity level for approximately one third of families referred to Healthy Start consistently fall within this high risk range of over 45 as shown below:

	FY 04	FY 05	FY 06
45+ (High Risk)	40% (1,662 / 4,145)	37% (1,540 / 4,195)	34% (1,416 / 4,198)

For FY 06, MCHB set an outcome goal of 100% of families enrolled for at least 12 months, would not have any incidences of abuse and/or neglect:

No. of families enrolled in regular Healthy Start for at least 12 months	No. of families with confirmed child abuse and /or neglect	No. of at risk families with NO confirmed child abuse and/or neglect
1,987	7	1,980 (99.65%)

FY 06 Variance report

The finding of 99.65% illustrates that a small number of families were reported and confirmed for abuse/neglect. However, by virtue of the home visitor's presence in the home, reported numbers would be expected to be higher than in the general population. That is, a home visitor is trained to conduct observations of parent-child interaction and will be more likely to refer a family for suspected child abuse and neglect by virtue of their knowledge of the family's strengths and weaknesses.

The following data is reported from the EHS Program (referrals made by CWS Division's FSS and VCM programs of families with children under one year of age).

Re-abuse in Family

4% reports of abuse/neglect – 11 out of 266 CWS referrals
3% confirmed reports – 8 out of 266 CWS referrals

Several reports were made by the providers to give additional information on existing situations which were referred to them and were seen as a "successful intervention" to obtain help for the family. These findings also demonstrate the EHS program's effectiveness in preventing re-abuse.

b. *Level System as part of Model Efficacy* – Under the current model, efficacy can best be demonstrated by reviewing how the Healthy Start Program tracks families' progress for risk reduction. The program uses a Level System with criteria for each level (prenatal through level X) which describes a family's needs for services (see Attachment C).

When a family initially enters the Hawaii Healthy Start Program, they are placed on Level I. Prenatal and IA represent those families that have either been referred to the program while mother is still pregnant, or who have been referred to the program and are still in the intake process. The case study below represents the majority of the kinds of situations considered Level IA.

A mother in ____ (island other than O'ahu) screened and assessed positive at the hospital but was ambivalent about accepting Healthy Start Services. The Family Assessment Worker was concerned about this mother because she had shared in the initial interview that her husband and children were on O'ahu. The Family Assessment Worker sent the mother a letter and her business cards a couple weeks after the interview in the hospital. She called her two weeks later to remind her that she could still accept services and just to check in and see how she was doing. Mother again was unsure about accepting services. Two weeks later, mother called the Family Assessment Worker and said that she was feeling very depressed, and she might send the baby to O'ahu and give up custody of her three older children. The Family Assessment Worker suggested that the mother might want to talk to the Clinical Specialist in the program. The mother agreed, spoke to the clinical specialist and initiated services. She not only kept the baby, but has her three older children with her and is currently very engaged in home visiting services.

The 512 families in Levels II, III, and IV, and the 350 families in Level Exception represent those families who are engaged with the Healthy Start Program and who have been assessed as progressing with risk reduction. The Level Exception families are placed on this level due to logistical factors rather than refusal of services. These Level Exception families would like to continue participation in the program, but cannot meet regularly with their home visitor due to work or other commitments despite evening and weekend visitation options.

Table 2: Numbers of families assessed with the current Level System for FY 06

Service Level	No. Ass'd All Levels	% of Total - All Levels	No. Ass'd fr Level II	% of Total - fr Level II
Prenatal	75	1.79		
1A	1,391	33.13		
I	586	13.96		
II	361	8.60	361	16.82
III	142	3.38	142	6.62
IV	9	0.21	9	.42
X	526	12.53	526	24.51
Exception	350	8.34	350	16.31
Worker Absent	20	0.48	20	.93
Other	3	0.07	3	.14
No Service Level Entered	735	17.51	735	34.25
Totals:	**4,198**	**100.00**	**2,146**	**100.00**

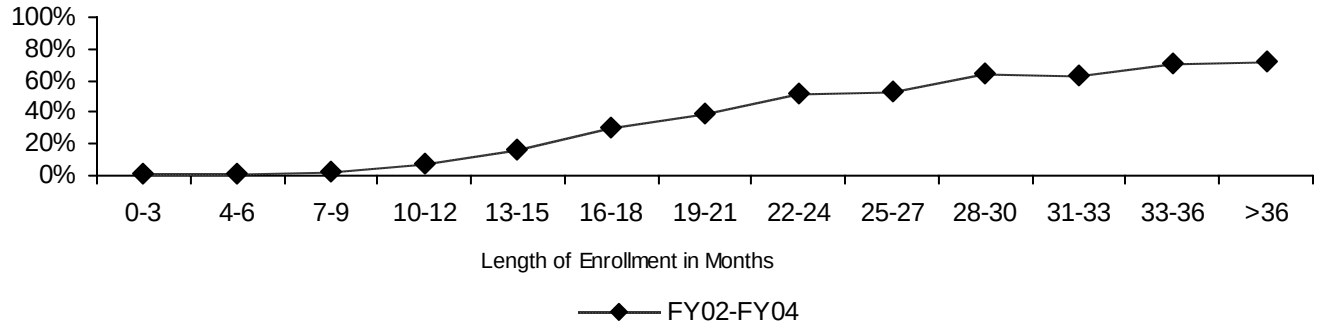
CHEIRS back end data, June 30, 2006

In order to measure progress, one cannot incorporate the number of Levels Perinatal, 1A, and I because these are cases where the family is still in "pre-engagement" or have just enrolled in the program. By counting only from Level II onward, these numbers would more accurately demonstrate families' "progress". Therefore, those families at Levels II, III, IV, and Exception represent approximately 40% of the program's census who are

engaged in the program and demonstrating progress (i.e. a reduction in family risk factors for child abuse and neglect).

Families assessed at Level X indicate the program's emphasis on creative outreach. Based on research and national trends, there is evidence that families with increased length of enrollment decrease their risk factors. The current program model recognizes this and embraces creative outreach services as a vital part of the home visiting program (see Table 3 below):

Table 3: Decrease in Risk at Discharge by Family Length of Enrollment
(As length of enrollment increased, the percent of families with a decrease in family risk at discharge increased) .



Johns Hopkins University, Healthy Start Program CHEIRS Analysis, SCR 13/45 Committee Indicators, July 20, 2006

Recognizing that some families may not have experience with someone who provides a consistent and supportive relationship, a certain amount of tenacity is required by home visitors that can prove to have significant positive outcomes. The current model requires that unless a family explicitly indicates that they no longer want Healthy Start home visiting services, programs will continue to reach out to Level X families for a minimum of 3 three months. The following are case studies from a neighbor island program demonstrating the importance of outreach to high risk families:

Case Studies:

- *One of our Mom's was missing multiple home visits. As a creative outreach effort, the Family Support Worker went to the fast-food restaurant where Mom worked to check on how she was doing and to explore when a home visit could be scheduled. This effort helped to re-engage Mom and led to addressing various family issues that were troubling the family.*

- *Another single mother was reunited with her son at the start of Healthy Start services. She was very reluctant to accept services. She was referred due to mental health issues, drug addiction and history of abuse in her own childhood. Our Family Support Worker, however, continued to meet mom whenever and wherever mom was willing to meet and she has since become strongly engaged. She is making good progress on her goals, seeing our therapist for mental health issues, engaging in our parent*

support groups, and has been sober for 12 months.

c. Office of Special Education Programs (OSEP) Special Conditions – Standards and protocols were evaluated in relation to the OSEP on-site monitoring conducted in November and December, 2005 and February, 2006. Monitoring was conducted in response to OSEP's finding of non-compliance in their June 5, 2002 Monitoring Report. Consistent monitoring and assistance have demonstrated a steady improvement toward compliance with federal guidelines. Additionally, the MCHB database was revised for easier monitoring and follow-up (see Attachment D). A review of the Attachment D demonstrates that Hawaii Healthy Start has made significant improvement toward compliance.

   The data presented in Attachment D represent numbers and percentages for the five special conditions that were found out of compliance by OSEP. When calculating the percent for compliance, the State was allowed to subtract from the denominator those records not in compliance due to "family reasons" – i.e.. if the particular activity was not completed in a timely manner, or not conducted due to a family's preference to decline the service, or the family's choice to delay decision making, then the record was not counted against the state.

d. Child Development screening and monitoring as part of model efficacy – Home visitation is an opportunity to regularly screen and monitor the development of Healthy Start children. Healthy Start children are monitored closely and referred for further evaluation to ensure early and appropriate intervention for developmental concerns. The Ages and Stages Questionnaire (ASQ) is a developmental screening tool administered when the child is 4 months, 6 months, 8 months, etc. Table 4 illustrates the number of (duplicated) children who were administered the ASQ at prescribed developmental milestones. If a child scores 2 standard deviations below the mean in one or more domain areas (communication, gross motor, fine motor, problem solving, personal-social, social-emotional); the child is referred to the program's Child Development Specialist and may be further referred for a comprehensive developmental evaluation. If the child's evaluation results demonstrate developmental delays, the child is referred for Early Intervention services which may include speech, occupational, and/or physical therapy.

   In FY 2006, 176 out of 2,269 (or approximately 7%) of Healthy Start children administered an ASQ were screened two standard deviations below the mean. Of these 176 children, 77 required further developmental evaluations for early intervention programs. The remaining 99 children received consultative services by a Child Development Specialist. Services may have included developmental interventions that could be instituted in the home by parents and a Family Support Worker, or upon further assessment by the Child Development Specialist, closer and more frequent monitoring would be recommended. Home visiting services affords these children the advantage of early detection for and referral to early intervention services.

Table 4: Number of children administered the ASQ for FY 06

ASQ Type (Age in Months)	ASQ Client Count	Client Count (2 Std. Dev. below Mean)	Number Evaluated
4	867	21	8
6	152	3	1
8	402	8	6
10	89	3	1
12	578	8	3
14	55	7	5
16	469	53	30
18	96	23	8
20	135	17	6
22	30	6	3
24	382	16	11
27	37	5	2
30	282	11	4
33	35	6	5
36	265	19	4
42	40	3	1
48	22	2	0
54	9	1	0
60	6	2	1
Total:	**3,951**	**214**	**99**
Unduplicated Total:	**2,269**	**176**	**77**

CHEIRS back end data, June 30, 2006

Table 5 illustrates the breakout of social emotional (SE) developmental screening administered to children (duplicated count) at prescribed developmental milestones for FY 2006. Approximately 2.4% (68 out of 2,845) of those children administered the ASQ-SE required further evaluation while the other 2,777 (or 97.6%) fell within acceptable score ranges.

Table 5: Breakout of 2,845 ASQ-SEs Administered for FY 06:

ASQ-SE Type (Age in Months)	Below Cutoff	Above Cutoff (Add' Evaluation may be Needed)	Above Cutoff that were Evaluated
6	780	10	0
12	585	9	3
18	455	6	1
24	372	14	1
30	293	14	2
36	256	13	0
48	28	1	1
60	8	1	0
Total:	**2,777**	**68**	**8**

CHEIRS back end data, June 30, 2006

Hawaii's data for children at risk for or demonstrating developmental delays fall within the 2nd - 7th percentiles. This supports the findings of Sweet and Appelbaum (a meta-analytic review of 60 home visiting programs across the United States)[1] which noted that children in families who were enrolled in home visiting programs fared better than did control group children.

Case Studies:

- *Mom was very appreciative of the books that were brought into the home. I demonstrated how books could be made for baby using construction paper, glue and magazine pictures.*

- *Child Development Specialist shows grandfather and grandmother how to make toys from cardboard and dried beans. The 8-month grandson they care for has no toys. The Child Development Specialist shows how stacking blocks help baby with muscles in fingers. The Child Development Specialist talks about the important stuff baby learns when he mouths the corners of the blocks. Both grandparents smile and nod as we teach how to help baby crawl on his tummy.*

- *The Child Development Specialist brings in beads and string, father watches as toddler attempts to string beads. The Child Development Specialist talks to dad about what the child is learning while playing. Dad encourages child and she does better with each attempt. The Child Development Specialist tells dad that Cheerios and a shoelace will make a similar activity. Dad says he does not teach child, in their culture they are usually allowed to learn themselves. The caregiver (aunt) watches to see that the child does not get hurt. The few toys the family has are broken or parts missing; books are scarce also.*

[1] Sweet, M.A. and Appelbaum, M.I., (September/October 2004, Volume 75, Number 5) "Is Home Visiting an Effective Strategy? A Meta-Analytic Review of Home Visiting Programs for Families with Young Children", *Child Development,* pages 1435 – 1456.

- *The Child Development Specialist brings in various textured materials to make cards with mom for baby. Baby is a premie and would benefit from more tactile stimulation. Foil from cookie packages, clear plastic ridged cookie containers, cellophane, sandpaper, and feathers are some items we used. Mom contributed some plastic wrap. After making the cards with mom, the Child Development Specialist role models "words" to use as baby feels the cards. Mom says, "I like the idea of using stuff we have at home."*

- *Mom is currently looking for permanent housing. The Child Development Specialist provides information about Self Regulation and shows mom how to make a mobile for her newborn. Mom chooses pictures of flowers and plans to teach baby colors while her baby watches the mobile. The Child Development Specialist points out that this mobile can be used to help baby self regulate to calm and settle down.*

- *One family had a child removed when the father burned his daughter with a lighter on her foot to "teach" her not to play with lighters. The mother and father initially refused services, but the program sent out several family support workers until one connected with them. The home was filthy, and on our initial visits, the infant was often laying on a filthy floor, covered with dirt and oily grease. At one visit, the Clinical Specialist walked in to find the baby on the floor with her head lodged under the sofa sucking on a bottle that had rolled under the couch. For months, the father of the baby refused to admit that he had burned his daughter – claiming she was playing with the lighter. The mother of the baby enabled his denial by discounting the severity of the punishment. Only recently has he admitted to our Clinical Specialist that he did burn her to teach her a lesson. Unfortunately, father has very limited cognitive abilities. Nevertheless, our Family Support Worker and the Clinical Specialist are able to engage with the family in learning positive discipline and realistic developmental expectations. Father is learning to put things out of reach of his children; to hold his children more often; to hold the baby while feeding her, and to bathe her more often, and place a clean blanket on the floor for the baby to play on. The team is helping the parents learn about hygiene and sanitation as well. The family is engaged in services and making progress.*

e. *Immunizations/Medical Home/Community Referrals as part of Model Efficacy* – Ensuring regular medical care for Healthy Start children is a strong component of the home visiting program and is demonstrated by the following data:

- No. of children and their families who have an identified medical home for well and sick care: 2,782 out of 2,900 or 95.9%

- No. of high risk children enrolled at 2 years of age who are fully immunized: 353 out of 456 or 76%, which compares favorably with the CDC data – The 2004 CDC Report shows Hawaii's statewide immunization rate for all children ages 19 to 35 months of age is 79.8%.

A review of the number of families served by the Clinical Specialists statewide for the last two quarters of FY 2006 revealed a significant number of families were referred to other,

outside community resources for substance abuse, family violence, and for mental health issues as follows:

FY 2006	Total No. of Consults Provided	Referrals to outside community resources for:		
		Substance Abuse	Family Violence	Mental Health
3rd quarter	942	63 (6.7%)	19 (2.0%)	49 (5.2%)
4th quarter	846	22 (2.3%)	56 (5.9%)	38 (4.0%)

FY06 Variance Report: 3rd and 4th quarter data reported based on start of new contracts in January, 2006 (unduplicated)

Percentages in the above table represent the percentage of referrals to the total number of consults for the quarter. Anecdotally, programs have reported a rising concern with the numbers of families requiring treatment for substance abuse. The majority of families referred through the CWS for the EHS Program are confirmed for substance abuse.

Case Studies:

- *With the support of the Clinical Specialist, a mother improved her self-confidence and terminated an unhealthy and unsafe relationship. This mother had been living in a violent relationship with her child's father for the past eight years. He had been arrested and rearrested due to numerous failed attempts at substance abuse treatment and at trying to maintain his sobriety. He was incarcerated at the time of referral; the consumer initially wanted to meet with the Clinical Specialist to discuss getting help for her daughters. Her concern had been that her daughters were repeatedly exposed to their violent relationship. She felt that some of their "acting out" behavior could be due to overhearing the verbal arguments the couple had over the phone. During the course of brief therapy with the Clinical Specialist, the mother decided to again be in a relationship with her child's father although he was still in prison. Although the couple was not living together, the Clinical Specialist noted that it appeared from information shared by the mother that he was trying to control her while he was incarcerated. The Clinical Specialist addressed these issues and referred the mother to the Family Peace Center (FPC), which would provide services to both her and her two eldest daughters. At first she was resistant to call and follow through with the FPC. However after much encouragement from the Clinical Specialist, she finally did follow-up with the referral. She currently participates in the FPC support group for victims and is in the process of enrolling her eldest daughters into the FPC play therapy groups. This mother has stated that the referral to the Family Peace Center has been a great support to her. She has gained strength from her peers and the group, and has decided to terminate her relationship with her abusive partner.*

- *Through the intervention of the Clinical Specialist, one mother was able to improve her self-esteem, as measured by pre and post-tests using the Hudson Scales. Her feelings about being a parent also improved significantly, as indicated by the Hudson Index of Parental Attitudes, with her post-test score dropping from 21 to 4, with higher scores indicating more concerns. In addition, this 21 year-old mother was able to*

resolve the relationship conflict with her sister-in-law and end her relationship with her child's teen aged father. She reports that her self-confidence has increased, she is better able to control her anger, is better able to verbalize her feelings, and that the communication between her and her parents and sister-in-law has greatly improved. She is now enjoying pursuing her education as a full time student at _____College.

- *Through the intervention of the Family Specialist, another mother learned much needed stress management skills. This consumer was burdened by financial worries, strained relationships, and uncertainty about her future. She is now managing her stress more effectively by recognizing automatic thoughts, evaluating negative thoughts, and identifying alternative ways of thinking that are more positive and solution focused.*

f. New protocol development – The Hawaii Healthy Start program has partnered with the federal CDC and JHU to study the effectiveness of a home visiting protocol. The proposed protocol is a cognitive retraining component explicitly defining specific actions to be performed during home visits. Training for the two pilot program sites has been completed and the study will progress through 2009 when it will expand to a main study sample and baseline data.

g. Cost effectiveness – The Hawaii Healthy Start program utilizes the MAS 90 accounting software that assists with timelier, more efficient, and more accurate reporting of financial information to management. It provides real time information on program expenditures as well as allocation status. The Healthy Start Program is able to use the MAS 90 software to generate reports to project future program expenditures on a prescribed timeline, or through ad hoc reports that can be generated in a timely fashion.

The MAS 90 data can also be stored for future analyses to examine the cost-benefits of interventions delivered through home visits. The Healthy Start Program has also increased its ability to utilize the CHEIRS (Child Health Early Intervention Record System) Database Management System for the reporting of program data. Data from this repository is regularly queried to produce ad hoc reports which assists with day to day programming activities (see Attachment E).

h Future projects --

IDEA Part C Family Survey: A statewide IDEA Part C Family Survey will be conducted in September, 2006 as part of the new federal "What Counts" initiative. Survey findings will be reported to OSEP in February, 2007.

Continued on-site assistance visits: MCHB will continue partnering with its training contractor, The Institute for Family Enrichment (TIFFE) to provide on-site technical assistance for OSEP compliance as well as support for implementation of recent revisions to the Healthy Start model.

Continued training and support for IFSP development and focus on fidelity to the model: TIFFE has revised its "core" training for Family Support Workers to ensure that the malleable risk factors are addressed in a service plan for the family. Additional training to

address the revised Level System and pilot testing of this system is scheduled to begin in October, 2007.

Collaboration with Hawaii Family Support Institute (HFSI) for training consistent with needs identified by MCHB: MCHB has partnered with DHS, PHNs and HFSI to develop collaborative training for social workers, nurses, and family support workers for a pilot in the Kalihi community. Planning has been instituted and actual training and collaboration is scheduled to start in the fall. HFSI has also supported the development of role specific training for the Clinical Specialists in response to the increasing acuity levels of the families Healthy Start serves.

In summary, model efficacy and cost effectiveness have been demonstrated in home visiting program activities with positive outcomes for confirmed child abuse and neglect cases, healthy child development, immunization rates, establishment of a primary medical care provider, collaboration with JHU and TIFFE for better training and protocol development, and fiscal accountability for program activities.

3. Corrective action to improve the inconsistent program implementation cited by the Johns Hopkins University and appropriate measures to retool with regard to Healthy Start providers deviating from the program model

The study identified program redesign and development needs to:

a. Incorporate program objectives into the Family Support Plan
b. Develop home visitor and supervisor skills to address family risks for abuse
c. Use theory-based protocols to structure home visits
d. Develop formal program relationships with community resources to assure service access and coordination

Corrective actions:

a. Provided training and technical assistance to Healthy Start providers toward IFSP development which addresses risk reduction. See Attachment F – Listing of Trainings (provided by The Institute for Family Enrichment)
b. Provided on-going training and technical assistance to home visitors and supervisors to address family risks for abuse; revise and realign current models for clinical services to support home visitors (final revision completed June, 2006)
c. Partnered with JHU and CDC on piloting a Hawaii Family Thriving home visiting protocol (ongoing – currently in data analysis of pilot study phase)
d. Develop collaborative relationships with CWS, WIC, MedQUEST Division and DOE to provide earlier (prenatal) intervention and a more seamless array of services available to the family with increased risks and stressors (WIC collaboration scheduled to begin in October, 2006)
e. Monthly meetings rather than quarterly meetings with program directors to encourage collaboration, and team building to address history of director and supervisor turnover.

Each of the above noted improvement activities and corrective actions have been described and discussed within the body of this report.

4. Development and implementation of new billing policies and procedures that best reflect accurate program costs and best practice

Following months of collaboration with contracted providers, a revised billing system was developed and implementation was scheduled for January, 2006 – the start of a new contract period. However, despite this close alliance, several of the contracted providers subsequently determined that the new billing system would not be acceptable as it would not fully support the cost of operating the program.

The initial proposed revisions incorporated the same unit rate; but with revised unit amounts per billable activity. The purpose for reducing payments per activity was to align the program costs with an anticipated reduction in legislative appropriation. When the proposal was rescinded, the billing system reverted back to the current system with a tacit agreement among providers that MCHB would continue to research and develop a new billing system.

The first part of the current analysis compared the current unit cost system to a flat rate method of payment. Based on a comparison of standards and opportunities for program monitoring and the current Medicaid reimbursement definitions, it appears that the unit cost method provides the best system of payment at this time.

Therefore, MCHB continued its revision activities to include a time study of Family Support Worker activities which was completed in May, 2006. Results of this study will yield average number of hours spent on program activities. Preliminarily, the new billing system would like to clarify billing activities to a more streamlined unit to ensure better accountability, to align activities to Medicaid reimbursable requirements, and to maintain department and procurement policies. MCHB has also asked for a voluntary submission of expenditure reports. Three programs submitted actual expenditure reports which will be used to assist our current analysis in determining true administrative costs.

Following this careful, deliberate and thorough analysis of all possible factors to consider when determining program costs, MCHB will then submit a proposal to revise the billing procedures. This will inevitably require another Request for Proposals as the current contract addresses specifically the “old” billing unit cost rate with “old” billing definitions in operation. The current contracts will run to 2009, however once a new billing system can be operational, the current contracts will be terminated and new contracts awarded to reflect these fiscal changes.

5. Findings and recommendations made by the Healthy Start Advisory Task Force and steps taken by the Healthy Start Program to implement the Healthy Start Advisory Task Force’s recommendations regarding its restructuring and priority redesign issues

Specific and detailed recommendations made by the Task Force are being reported to the Legislature in a separate report. Please refer to this report for a comprehensive discussion.

The Task Force developed a Logic Model which includes Long-Term Outcomes, Short-Term Indicators, Implementation Benchmarks, and specific Program Elements. In addition to keeping with initial program objectives for prevention of child abuse and neglect, increasing

family self-sufficiency, and improving child health and developmental outcomes, the Task Force also addressed the following program model issues:

Paraprofessional Model – The Task Force examined the current two-tiered system. Families enter the program via a screening and assessment procedure which usually occurs in the hospital following the birth of a baby. A second tier to the program encompasses the "Enhanced" Healthy Start program which are families referred for home visiting services through their Department of Human Services, Child Welfare Services social worker. These families have either been investigated and abuse or neglect confirmed, or receive CWS services through the department's Voluntary Case Management program, or Family Strengthening program. The program is "enhanced" because of additional professional support; i.e., a registered nurse and Certified Substance Abuse Counselor.

Within the regular Healthy Start program, paraprofessionals have Child Development Specialists and Clinical Specialists available for consultation. The Task Force noted the high acuity levels of families (refer to Table 1 for a reference of Kempe Family Stress Checklist scores for families entering the regular Healthy Start Program), and noted that as acuity rose, professionals were required to provide more direct services (versus providing consultation to the home visitors). The Task Force will be recommending an increase in specialist positions for programs particularly for the Child Development Specialist (CDS) positions. The CDS would then be able to support more child development concerns in direct response to increased OSEP requirements. It would thereby allow Home Visitors more time to focus on family risk factors.

Engagement Points: In addition to generating a list of possible referral sources and entry points into the Healthy Start Program, the Task Force also discussed expanding its window for referral from the current 0-12 months of age to 0-30 months of age. This would allow families lost to the program despite intensive outreach to return to the program when family and personal circumstances allowed.

Engagement Strategies: The Task Force also generated a list of strategies to engage families with the Healthy Start program. Contractual agreements with other Department of Health POS providers was discussed as a viable and seamless strategy to reach families at risk for child abuse and neglect.

Retention: The Task Force recognized the venue for "home visiting" may not always be culturally appropriate for the families the program serves. Therefore the program model can be revised to allow for visiting and interventions to occur outside of a family's residence. Again, the Task Force recognized a variety of ways to ensure that families enrolled in the program would want to stay in the program. Father involvement was also discussed and noted as a possible area for further development.

Curriculum Development and Training: Again cultural appropriateness of the program model was noted along with curriculum development consistent with the proposed Logic Model. The Task Force discussed the merits of determining one curriculum for all programs, however members were divided between the virtues of the consistency of one curriculum or giving individual programs the option of tailoring a specific curriculum to the community the program serves.

As noted in the beginning of this report, other recommendations (Level System revision, Child Development Specialist model revision, and Clinical Specialist model revision) were also made by the Task Force, and developed and readily incorporated by the Healthy Start program to the extent possible.

Summary

In its comprehensive, extensive and multi-disciplinary review of research on early development and the role of early experiences, a committee of national academies found "scientific evidence on the significant developmental impacts of early experiences, caregiving relationships, and environmental threats is incontrovertible".[2] The committee found that programs that combine child-focused educational activities with explicit attention to parent-child interaction patterns and relationship building appear to have the greatest impact.

The Hawaii Healthy Start Program continues to move forward in its improvement plan, mindful that Task Force revisions may require further program model changes. By keeping its focus on fidelity to the program model of family strengthening and promoting positive parent-child relationships, any further revisions and changes should still allow for sustained improved program outcomes.

The Hawaii Healthy Start Program will continue to require program monitoring via tracking outcomes utilizing its data management system, on-site program contract monitoring, tracking family satisfaction with the program and documentation of family success stories, tracking outcomes based on Department of Human Services/Child Welfare Services system of care data, and formal evaluations via resources such as the Centers for Disease Control and Prevention study and collaboration with Johns Hopkins University.

[2] Jack P. Shonkoff and Deborah A. Phillips, Editors; Committee on Integrating the Science of Early Childhood Development, Board on Children, Youth, and Families. *From Neurons to Neighborhoods: The Science of Early Childhood Development*, 2000.

Attachment A

MCHB CHILD DEVELOPMENT SPECIALIST MODEL

The responsibility of the Child Development Specialist (CDS) is to provide services focused on child development and parent child interactions. The purpose is to support the optimal growth and development of children. Services include assessment, intervention, consultation/training, and care coordination.

A. Required Referrals to CDS Within Five (5) Working Days of Identified

Concern:

1. One SD in one developmental domain consecutively from one assessment period to the next (One SD in Gross Motor at four months and again at six months) on the ASQ.
2. One SD in more than one developmental domain on the ASQ.
3. Two SD in any developmental domain on the ASQ.
4. ASQ-SE with score above cut-off.
5. Six Month Teach 44 and below
6. 18 Month Teach 46 and below
7. Feed one at one - five months 49 and below
8. Feed done at six to twelve months 54 and below
9. HOME at four – eight months 32 and below
10. FSW, CS, or parent concern on child development issues
11. Program specific referrals, e.g., scores on the Family Stress Checklist.

B. CDS Service Options Shall Include:

1. Assessment

- Use appropriate tools to assess child's development.
- Use appropriate tools to assess parent child interactions.
- Observe parent and child in their natural environment and group settings.

2. Intervention

- Demonstrate child development activities for families.
- Provide role modeling at home visits.
- Provide advice and support to parents regarding child. development, parent child interactions, and participation in Early Intervention services.

Attachment A

MCHB CHILD DEVELOPMENT SPECIALIST MODEL

3. Consultations/Trainings

- Recommend and demonstrate intervention activities and role modeling to other staff regarding child development and parent child interactions.
- Provide technical assistance to other staff regarding interventions related to child development and parent child interactions.
- Assist staff in the development of the IFSP, e.g. present level of development and outcomes.
- Conduct trainings for families and staff in child development issues and/or various developmental screening tools.
- Explain information from the comprehensive developmental evaluation (CDE) to staff.

4. Care Coordination

- Coordinate request for a CDE within two weeks of referral to CDS.
- Notify pediatrician of the CDE request within two weeks of referral to CDS.
- Provide outreach to parents for acceptance of CDE referral.
- Participate in CDE as appropriate.
- Refer families to Early Intervention services as needed.

C. Documentation of CDS service:

Documentation should include reasons for referral, service plans, all services provided, e.g. assessment, intervention, consultation, and care coordination, and outcomes.

Attachment B

MCHB CLINICAL SPECIALIST MODEL

The responsibility of the Clinical Specialist (CSp) is to provide services focused on family psychosocial issues including family violence, mental health, and substance abuse. The purpose is to support the optimal growth and development of children. The primary services are consultation, referral, training, assessment, and short term intervention. The CSp services supplement the Family Support Worker's (FSW) and the Clinical

A. CSp Referrals

1. Procedure:

a. Identify concerns:
   1. FSW and CS identify concerns that may benefit from consultation and/or training from the CSp
   2. FSW and CS identify concerns that could be addressed through CSp assessment and intervention services.

b. Within five working days of identifying concerns, a referral form is sent to the CSp.

2. Identified concerns include but are not limited to:

a. Relationship difficulties, including family violence
b. Substance abuse
c. Mental health
d. Family crisis

B. CSp Service Options:

1. Consultation and Training

The CSp services include individual consultation and group training to families and staff on topics relating to the identified concerns (listed above) and on other topics as appropriate to staff and families' needs.

a. Examples for Staff:

1. Interpret or explain clinical concerns on the EID Intake and/or other records.
2. Educate staff on how to identify typical warning signs of family violence, substance abuse, and mental health issues.
3. Equip staff with ways to encourage families to accept CSp services when appropriate.
4. Prepare staff to given an appropriate response to consumers in crisis.

b. Examples for Families:

1. Educate families on how to self-assess and identify warning signs of family violence, substance abuse, and mental health issues.
2. Help families to create a safety plan.
3. Encourage families to access community resources, including short-term therapeutic services, when appropriate.

2. Assessment and Intervention

The CSp services include assessment and intervention to families who are treatment ready and who may benefit from short-term intervention or support for follow up of private providers' treatment recommendations.

a. Examples of Assessment

1. Assist in the development of IFSP objectives, which pertain to identified concerns and CSp services.
2. Complete a Psychosocial Assessment for a family.

b. **Examples of Intervention**

1. Develop with the family a Service or Care Plan, identifying goals pertinent to CSp services.
2. Provide short term interventions to address identified concerns. CSp services may be extended if community services are not available or appropriate.
3. Encourage families to access community services, including on-going therapy, when appropriate.
4. Follow-up with the family, when possible, to confirm and support families' use of community resources.

C. Documentation of CSp Service Services:

Documentation includes reasons for referral, concerns addressed in CSp services, goals and progress, CSp services provided (e.g., consultation, training, assessment, and intervention), and referrals offered to family as appropriate for each referral.

- **Examples of Documentation:**

a. Psychosocial Assessment
b. Service or Care Plans
c. Pre and Post Tests
d. Progress Notes
e. Quarterly Reporting

Attachment C
MCHB Level System

Prenatal**:** Family Support Worker (FSW) shares information with participant regarding prenatal care, fetal development birthing process, and preparation for the new born. FSW encourages and supports the participant in discussing a birth plan with her OB/GYN or primary care provider.

Level IA: Use either at the start of a postnatal admission, or when converting a prenatal admitted new client to postnatal services. If prenatal participant is fully engaged at birth, may move from Prenatal to Level I.

Level 1: For Participants with Family Stress Checklist (FSC) scores of 40 and above, FSW makes at least one home visit per week for a minimum of 6 months after the birth of the infant. For Participants with FSC scores below 40, one monthly group contact may be substituted for a home visit.

Level 2: FSW to make at least one home visit every other week and a telephone call in the week when no home visit is made. FSW to monitor child's development as documented by screens/assessments (HOME, TEACH, ASQ, ASQ-SE), make referrals and advocate for services needed to enhance development or treat delays. FSW to monitor child's health needs which include well baby check-ups and immunizations. FSW to continue to teach and conduct activities required by parent-child interaction curriculum including effective, nonviolent discipline.

Level 3: FSW makes at least one home visit per month and a weekly telephone call between monthly home visits. FSW continues to support participant in engaging in developmentally appropriate activities with target child including school readiness activities required by parent-child interaction curriculum. Provide ongoing emphasis of positive non-violent discipline strategies.

Level 4: Participant maintains stability in the home for at least 90 days, or responds appropriately to crisis. Participant regularly utilizes at least two positive support networks or individuals outside the Healthy Start program. Participant consistently demonstrates nurturing, positive parent-child interaction skills. Participant and child have a medical home. Participant takes child to all scheduled well care and is attentive to child's medical needs.

Level X: New participant who has accepted referral and contact has been established yet participant evades or does not allow contacts during the first 45 days of service on Level IA. The FSW employs creative outreach approaches for building trust and program participation. Supervisor provides guidance in determining frequency and specific strategies. Participant remains on Level X for a maximum of three months until they engage in services or are discharged. If participant clearly states or indicates that they do not want to continue services, the family should be discharged.

Attachment C
MCHB Level System

Exception: Participant is willing to continue services, but due to scheduling circumstances, at supervisor's discretion, is unable to meet the required number of HV's for their normal level. Scheduling circumstances may exist regardless of program's efforts to offer flexible visits including evening and weekend visits. FSW makes at least one home visit per month, preferably two, and a weekly telephone call.

Attachment D-1
Office of Special Education Programs Monthly Monitoring Data

Monthly monitoring results for Office of Special Education: The following 5 indicators or "special conditions" were found to be out of compliance by the federal monitors and require monthly monitoring. Data is submitted to the Dept. of Health lead agency – Early Intervention Services and subsequently submitted to the Office of Special Education.

Indicator 1: CDE completed within 45 days of referral
This data represents those children who scored 2 standard deviations below the mean on the developmental screenings – Ages and Stages Questionnaire. After consultation with the program's Child Development Specialist, the child was referred for a Comprehensive Developmental Evaluation (CDE). According to the Individuals with Disabilities Act, Part C, the CDE must be completed within 45 days of referral. Cumulative data for FY 06 demonstrates improved compliance with this measure. "Y" is the number of children who had a CDE done within 45 days; "NP" is the number of children whose CDE was not done within 45 days due to a program reason; "NF" is the number of children whose CDE was not done within 45 days due to a family reason; "TC" is the total number of children who should have had a CDE done within 45 days. The "NF" is subtracted from the denominator when determining final percentages since the program should not be penalized for a family's right to refuse or delay services.

Indicator 2: IFSP contains present levels of development
This indicator was found non compliant by the federal monitors. Federal monitoring determined that programs did not document the child's level of development on the Individual Family Support Plan. Use the same formula/definitions for "Y", "NP", "NF", and "TC". Program compliance has improved significantly for this indicator.

Indicator 3: Transition plans discussed
This indicator illustrates the programs' compliance with discussing a transition plan with the child's family at the IFSP meeting. Federal monitoring found that this was not adequately documented on the IFSP form. Program compliance has improved significantly for this indicator.

Indicator 4: Transition notices sent
This indicator would document those children transitioning out of the Healthy Start program into a Dept. of Education special education program. These notices must be sent out in a timely manner to meet compliance. Fortunately, the numbers of Healthy Start children leaving the program and requiring special education services is minimal; however the programs do require closer monitoring for better compliance.

Indicator 5: Transition Conference
This indicator represents the number of transition conferences held before a child exits the Healthy Start program. Again the numbers of children requiring assistance with transitioning to another program is minimal. Most Healthy Start parents find that they prefer arranging child care or preschool services on their own, and decline this service.

State of Hawaii
Indicator 1: CDE completed within 45 days of referral

AGENCY	JULY				AUGUST				SEPTEMBER				OCTOBER				NOVEMBER				DECEMBER				JANUARY				FEBRUARY				MARCH				APRIL				MAY				JUNE			
	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC
Catholic Charities Hawaii	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	0	0	1	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	No Children				No Children				No Children				100%				100%				No Children				100%				No Children				No Children				No Children				No Children				No Children			
Child & Family Service - Oahu	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	4	0	0	4	0	0	2	2	2	0	0	2	3	1	0	4	3	0	0	3	2	2	0	4	4	0	1	5	0	0	0	0
	No Children				No Children				No Children				100%				100%				NA				100%				75%				100%				50%				100%				No Children			
Child & Family Service - Kauai	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	No Children				No Children				No Children				100%				No Children				No Children				100%				No Children				No Children				No Children				No Children				No Children			
Family Support Services of West Hawaii	0	1	0	1	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	0%				0%				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children			
Maui Family Support Services	4	0	0	4	1	0	0	1	0	1	1	2	1	0	0	1	0	0	0	0	1	0	0	1	0	0	2	2	5	0	0	5	0	0	0	0	0	0	0	0	2	0	0	2	1	0	0	1
	100%				100%				0%				100%				No Children				100%				NA				100%				No Children				No Children				100%				100%			
PACT Hana Like Home Visitor	2	1	0	3	3	3	0	6	3	0	1	4	1	0	0	1	1	1	0	2	1	0	0	1	0	0	1	1	0	1	0	1	2	1	0	3	0	0	0	0	1	0	0	1	0	0	0	0
	67%				50%				100%				100%				50%				100%				NA				0%				67%				No Children				100%				No Children			
YWCA of Hawaii Island	2	0	0	2	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0
	100%				No Children				No Children				100%				No Children				No Children				No Children				No Children				100%				No Children				No Children				No Children			
FSS Molokai(Start Jan 2006); PPAS Molokai (End Dec 2005)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children			
TOTAL	8	2	0	10	4	4	0	8	3	1	2	6	6	0	0	6	6	1	0	7	2	0	2	4	5	0	3	8	8	2	0	10	13	1	0	14	2	2	0	4	7	0	1	8	1	0	0	1
	80%				50%				75%				100%				86%				100%				100%				80%				93%				50%				100%				100%			

Corrective Action Plan			
Indicator	Timeline	Strategies	Status/Evidence of Change
CDEs completed within 45 days of referral	75%-Jan. 2006 100%-April 2006	October, 2005: Statewide CDE training for the Healthy Start programs. Child Development Specialists for each program will be trained regarding administering the HELP Care coordinators at each program can also authorize CDEs through an Authorization for Services system. November, 2005: Monthly CHEIRS referral and evaluation data will begin during the month of December. Prior to December, (until CHEIRS edits are completed), providers will be required to manually count/review cases for compliance. January, 2006: With the new CHEIRS edits completed, monitoring will include follow up with individual program sites for specific cases noted on the report which are not in compliance. Programs will be asked to manually validate non-compliant cases and report back to MCHB regarding reasons for non-compliance. February, 2006: Healthy Start Nurse will be convening all Child Development Specialists to discuss status of comprehensive developmental evaluations, referrals, q & a, etc. On-site re-monitoring was conducted at one site per contract. April, 2006 MCHB continues to edit and review data management system to accurately reflect CDE referrals.	Statewide CDE trainings for Child Development Specialists were completed in November, 2005 August, 2005 The significant decrease in overall percentages for the month of August was due to 3 children in one program not receiving timely CDEs, however the program has since achieved substantial compliance (100% for the following 2 months) Monthly Gap reports should indicate 0 names on the list confirming that CDEs are completed in a timely manner. July-Sept, 2005 Monthly OSEP data monitoring through CHEIRS indicates that months not in 100% compliance were due to 1-4 cases not completed in a timely manner. December, 2005 Data for December was validated and improved following individual follow up with the programs. Programs were not inputting data correctly into the system which resulted in inaccurate data being reported. Following MCHB follow up, data was corrected and demonstrated 100% compliance. Note: Comprehensive developmental evaluations are conducted for Healthy Start consumers when there is a 2 standard deviation from the mean on ASQs. The first ASQ is administered at 4 months of age. June 2006 Data continues to be positive, however as more programs begin partnering with other entities to conduct the CDE, the numbers should increase and MCHB will continue to offer support and assistance to ensure compliance.

Indicator 2: IFSP contains present levels of development

AGENCY	JULY				AUGUST				SEPTEMBER				OCTOBER				NOVEMBER				DECEMBER				JANUARY				FEBRUARY				MARCH				APRIL				MAY				JUNE			
	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC
Catholic Charities Hawaii	5	0	0	5	1	0	0	1	0	0	0	0	4	0	0	4	2	0	0	2	2	0	0	2	0	4	0	4	6	0	0	6	9	0	0	9	7	0	0	7	10	0	0	10	8	0	0	8
	100%				100%				No Children				100%				100%				100%				0%				100%				100%				100%				100%				100%			
Child & Family Service - Oahu	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC
	26	4	0	30	30	4	0	34	33	5	0	38	44	0	0	44	26	0	0	26	19	0	0	19	22	1	0	23	17	1	0	18	36	0	0	36	22	0	0	22	17	0	0	17	19	0	0	19
	87%				88%				87%				100%				100%				100%				96%				94%				100%				100%				100%				100%			
Child & Family Service - Kauai	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC
	5	0	0	5	4	0	0	4	0	0	0	0	1	0	0	1	0	0	0	0	3	0	0	3	3	0	0	3	2	0	0	2	6	0	0	6	5	0	0	5	4	0	0	4	4	0	0	4
	100%				100%				No Children				100%				No Children				100%				100%				100%				100%				100%				100%				100%			
Family Support Services of West Hawaii	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC
	2	2	0	4	3	5	0	8	6	7	0	13	0	3	0	3	3	3	0	6	2	0	0	2	3	2	0	5	8	0	0	8	4	0	0	4	7	0	0	7	5	0	0	5	4	0	0	4
	50%				38%				46%				0%				50%				100%				60%				100%				100%				100%				100%				100%			
Maui Family Support Services	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC
	15	3	0	18	5	2	0	7	9	3	0	12	8	0	0	8	0	0	0	0	14	0	0	14	13	0	0	13	5	0	0	5	0	3	0	3	8	0	1	9	8	0	0	8	14	1	0	15
	83%				71%				75%				100%				No Children				100%				100%				100%				0%				100%				100%				93%			
PACT Hana Like Home Visitor	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC
	3	0	0	3	4	1	0	5	0	0	0	0	21	7	0	28	9	0	0	9	22	0	0	22	27	0	0	27	36	0	0	36	49	0	0	49	28	0	0	28	30	0	0	30	27	0	0	27
	100%				80%				No Children				75%				100%				100%				100%				100%				100%				100%				100%				100%			
YWCA of Hawaii Island	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC
	11	0	0	11	14	0	0	14	7	0	0	7	11	0	0	11	5	6	0	11	5	0	0	5	7	0	0	7	6	0	0	6	8	0	0	8	8	0	0	8	5	0	0	5	16	0	0	16
	100%				100%				100%				100%				45%				100%				100%				100%				100%				100%				100%				100%			
FSS Molokai(Start Jan 2006); PPAS Molokai (End Dec 2005)	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC
	1	0	0	1	2	0	0	2	3	1	0	4	1	0	0	1	1	0	0	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	100%				100%				75%				100%				100%				NA				No Children				No Children				No Children				No Children				No Children				No Children			
TOTAL	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC
	68	9	0	77	63	12	0	75	58	16	0	74	90	10	0	100	46	9	0	55	67	0	1	68	75	7	0	82	80	1	0	81	112	3	0	115	85	0	1	86	79	0	0	79	92	1	0	93
	88%				84%				78%				90%				84%				100%				91%				99%				97%				100%				100%				99%			

Corrective Action Plan			
Indicator	Timeline	Strategies	Evidence of Change
IFSP contains present levels of development (PLOD)	January 2006 – 90% April 2006 – 100%	November, 2005 Revise CHEIRS database to eliminate the default to "yes" for PLODs December, 2005 Programs will be required to submit a written plan for systemic changes to ensure that PLODs are completed appropriately November/December, 2005 On-site monitoring to validate July, August, September data Provide direct consultation to FSSWH to institute immediate training for FSWs to address PLOD documentation Provide direct consultation to Maui and CFS to address PLOD documentation. Consultation also provided to Maui regarding appropriate developmental stages. January, 2006 Request that programs send in documentation of PLODs on a randomly selected basis. Healthy Start Nurse will consult with programs for appropriate developmental milestones and activities. Healthy Start Program Specialist to follow up with programs to ensure that they are entering PLOD data. February, 2006 On-site monitoring was conducted at one site per contract April, 2006 There has been a tremendous improvement. In addition to the number of total IFSPs, completed PLODS per month increased. From July 2005 to present, the range of "yes" was 46-112, an average of 74 IFSP/PLODs per month. For the month of April there were 85 completed PLODs at 100%	December 2005 – CHEIRS report #53 will be accessed for OSEP monthly reporting data. After validation by the program specialist, compliance has improved from 84% to 100% February, 2006 – Results of on-site monitoring indicated improvement in PLOD documentation. Monthly follow up with programs routinely include asking programs to fax selected IFSPs to MCHB. This allows MCHB to validate data as well as review for qualitative monitoring.

Indicator 3: Transition Plans which contain discussion in all transition areas at least 90 days prior to child's 3rd birthday or start of home school

AGENCY	JULY				AUGUST				SEPTEMBER				OCTOBER				NOVEMBER				DECEMBER				JANUARY				FEBRUARY				MARCH				APRIL				MAY				JUNE			
	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC
Catholic Charities Hawaii	0	0	1	1	0	0	0	0	0	0	0	0	3	0	1	4	2	0	0	2	0	0	1	1	0	0	0	0	0	0	2	2	0	3	0	3	0	0	0	0	0	0	0	0	2	0	0	2
	NA				No Children				No Children				100%				100%				NA				No Children				NA				0%				No Children				No Children				100%			
Child & Family Service - Oahu	0	0	1	1	1	0	0	1	0	0	1	1	4	2	0	6	3	0	1	4	4	0	1	5	2	0	3	5	5	3	3	11	11	2	0	13	10	0	0	10	5	0	0	5	11	0	0	11
	NA				100%				NA				67%				100%				100%				100%				63%				85%				100%				100%				100%			
Child & Family Service - Kauai	0	0	0	0	0	0	0	0	1	0	0	1	5	0	0	5	2	0	0	2	0	0	0	0	1	0	0	1	0	0	2	2	2	0	0	2	2	0	0	2	1	0	0	1	1	0	0	1
	No Children				No Children				100%				100%				100%				No Children				100%				NA				100%				100%				100%				100%			
Family Support Services of West Hawaii	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	1	3	5	1	0	2	3	0	2	0	2	0	0	0	0	0	1	0	1	0	1	1	2	3	0	3	6	1	0	1	2
	No Children				No Children				100%				No Children				50%				100%				0%				No Children				0%				0%				100%				100%			
Maui Family Support Services	0	0	0	0	0	0	0	0	1	0	0	1	2	0	2	4	2	0	0	2	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	3	6	6	0	0	6
	No Children				No Children				100%				100%				100%				100%				No Children				No Children				No Children				No Children				100%				100%			
PACT Hana Like Home Visitor	0	0	0	0	0	0	0	0	0	0	0	0	12	2	2	16	7	0	2	9	7	1	5	13	5	0	0	5	7	0	0	7	12	4	0	16	8	2	0	10	5	0	0	5	1	2	4	7
	No Children				No Children				No Children				86%				100%				88%				100%				100%				75%				80%				100%				33%			
YWCA of Hawaii Island	0	0	0	0	1	0	0	1	1	0	0	1	1	0	0	1	0	0	0	0	0	0	0	0	0	0	2	2	4	0	4	8	4	0	0	4	2	0	0	2	3	0	0	3	5	0	0	5
	No Children				100%				100%				100%				No Children				No Children				NA				100%				100%				100%				100%				100%			
FSS Molokai(Start Jan 2006); PPAS Molokai (End Dec 2005)	0	0	0	0	0	0	0	0	1	0	0	1	1	0	0	1	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	2	0	0	2	0	0	0	0	3	0	0	3
	No Children				No Children				100%				100%				No Children				No Children				100%				No Children				No Children				100%				No Children				100%			
TOTAL	0	0	2	2	2	0	0	2	5	0	1	6	28	4	5	37	17	1	6	24	17	1	9	27	9	2	5	16	16	3	11	30	29	10	0	39	24	3	1	28	20	0	6	26	30	2	5	37
	NA				100%				100%				88%				94%				94%				82%				84%				74%				89%				100%				94%			

Corrective Action Plan			
Indicator	Timeline	Strategies	Evidence of Change
Transition Plans completed prior to the child's 3rd birthday or start of home school	January 2006 – 90% April 2006 – 100%	October, 2005 Provide consultation to all programs regarding switching to the new IFSP form – particularly for older target children in the program. November, 2005 During on-site monitoring, monitors noted that transition plans were documented in the anecdotal notes rather than in the IFSP. Consultation provided to train programs to document transition plans in the IFSP. Revise CHEIRS database to capture this information for monthly reporting January, 2006 Request programs to send in transition plans on a randomly selected basis. March, 2006 Overall percentages dropped because we recalculated for inaccurate "family reasons" listed. April, 2006 Four providers were at 100% and one at 80%. One provider with 0% (FSS W. Hawaii) has been consistently low. MCHB continues to work closer to offer additional support and they are working on stabilizing their staffing problems.	December, 2005 No improvement noted, (94%), however percentages reflect only 1 child whose transition plan was not completed in accordance with OSEP regulations. February 2006 On-site monitoring re-looked at specific records cited in November/December. Monitors observed evidence that corrections had been completed. June, 2006 Revised instructions were disseminated to programs regarding clarification of discussion of transition plans. This was also reflected in revisions made to CHEIRS – changing data fields to reflect "discussion" of rather than "completion" of transition plans.

Indicator 4: Transition Notices submitted at least 90 days of 3rd birthday or start of home school

AGENCY	JULY				AUGUST				SEPTEMBER				OCTOBER				NOVEMBER				DECEMBER				JANUARY				FEBRUARY				MARCH				APRIL				MAY				JUNE			
	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC
Catholic Charities Hawaii	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children			
Child & Family Service - Oahu	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	2	0	0	2	0	0	0	0	0	1	0	1	0	1	0	1	1	0	0	1	1	0	0	1	0	0	0	0	0	1	0	1
	No Children				No Children				No Children				100%				100%				No Children				0%				0%				100%				100%				No Children				0%			
Child & Family Service - Kauai	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children			
Family Support Services of West Hawaii	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children			
Maui Family Support Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children			
PACT Hana Like Home Visitor	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	2	0	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	No Children				No Children				No Children				0%				100%				No Children				No Children				No Children				No Children				No Children				No Children				No Children			
YWCA of Hawaii Island	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children				No Children			
FSS Molokai(Start Jan 2006); PPAS Molokai (End Dec 2005)	0	0	0	0	0	0	0	0	0	0	0	0	1	2	0	3	4	0	1	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	No Children				No Children				No Children				33%				100%				No Children				No Children				No Children				No Children				No Children				No Children				No Children			
TOTAL	0	0	0	0	0	0	0	0	0	0	0	0	2	4	0	6	8	0	2	10	0	0	0	0	0	1	0	1	0	1	0	1	1	0	0	1	1	0	0	1	0	0	0	0	0	1	0	1
	No Children				No Children				No Children				33%				100%				No Children				0%				0%				100%				100%				No Children				0%			

Corrective Action Plan			
Indicator	Timeline	Strategies	Evidence of Change
Transition Notices submitted at least 90 days of 3rd birthday or start of home school	85% by January, 2006; 100% by April 2006	November, 2005 Revise CHEIRS database to capture this information for monthly reporting January, 2005 Healthy Start Program Specialist to follow up with individual program sites to determine reasons for con compliance Data for Healthy Start children is very low due to the program's voluntary nature. Less than 4% of children demonstrate developmental delays and if they remain in the Healthy Start program, they are most likely to be known to other community entities who are generally the care coordinators (who would take the lead for transition planning, etc.)	December, 2005 Last month of compliance data indicated 100% for November, 2005 June, 2006 Data for this group of children continues to remain low due to the nature of Healthy Start's program model.

Indicator 5: Transition Conference held at least 90 days of 3rd birthday or start of home school

AGENCY	JULY				AUGUST				SEPTEMBER				OCTOBER				NOVEMBER				DECEMBER				JANUARY				FEBRUARY				MARCH				APRIL				MAY				JUNE			
	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC	Y	NP	NF	TC
Catholic Charities Hawaii	0	0	0	0	0	1	0	1	0	1	0	1	3	0	1	`	2	0	0	2	2	1	0	3	0	0	0	0	0	0	2	2	0	0	3	3	0	0	0	0	0	0	0	0	2	0	0	2
	No Children				0%				0%				100%				100%				67%				No Children				NA				NA				No Children				No Children				100%			
Child & Family Service - Oahu	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	3	0	1	1	2	2	7	4	13	4	0	1	5	4	1	6	11	2	2	9	13	2	0	8	10	1	0	8	9	3	0	8	11
	No Children				No Children				No Children				50%				0%				22%				100%				80%				50%				100%				100%				100%			
Child & Family Service - Kauai	3	0	0	3	4	0	0	4	0	0	0	0	5	0	0	5	0	0	0	0	0	0	0	0	0	0	1	1	0	0	2	2	0	0	2	2	1	0	1	2	1	0	0	1	0	0	1	1
	100%				100%				No Children				100%				No Children				No Children				NA				NA				NA				100%				100%				NA			
Family Support Services of West Hawaii	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	3	0	3	2	5	1	1	1	3	0	2	0	2	0	0	0	0	0	0	1	1	1	1	0	2	0	0	3	3	1	0	1	2
	No Children				No Children				No Children				0%				0%				50%				0%				No Children				NA				50%				NA				100%			
Maui Family Support Services	1	0	0	1	1	0	0	1	0	0	0	0	2	0	2	4	0	0	0	0	2	0	3	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	1	3	6	0	0	6
	100%				100%				No Children				100%				No Children				100%				No Children				No Children				No Children				No Children				100%				100%			
PACT Hana Like Home Visitor	2	0	2	4	3	0	0	3	0	0	1	1	9	1	0	10	3	0	3	6	5	1	7	13	3	0	2	5	1	0	6	7	2	2	12	16	1	0	9	10	1	0	4	5	0	0	5	5
	100%				100%				NA				90%				100%				83%				100%				100%				50%				100%				100%				NA			
YWCA of Hawaii Island	3	0	0	3	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	1	0	1	2	3	0	1	4	2	0	0	2	1	0	2	3	0	0	5	5
	100%				100%				No Children				No Children				No Children				No Children				NA				100%				100%				100%				100%				NA			
FSS Molokai(Start Jan 2006); PPAS Molokai (End Dec 2005)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	0	0	1	2	0	0	2	0	0	0	0	3	0	0	3
	No Children				No Children				No Children				NA				No Children				No Children				100%				No Children				100%				100%				No Children				100%			
TOTAL	9	0	2	11	10	1	0	11	0	1	1	2	20	4	6	30	5	4	6	15	12	10	15	37	8	2	6	16	6	1	17	24	8	4	28	40	9	1	18	28	6	0	18	24	15	0	20	35
	100%				91%				0%				83%				56%				55%				80%				86%				67%				90%				100%				100%			

Corrective Action Plan			
Indicator	Timeline	Strategies	Status/Evidence of Change
Transition Conferences held at least 90 days prior to child's 3rd birthday or start of home school.	75%-Jan. 2006 100%-April 2006	November, 2005 Provide consultation to programs specifically for children who are "environmentally at risk" and for families declining DOE Part B services who will not be attending a DOE program. Emphasize to programs the importance of documenting the family's declination of referral for evaluation services. Revise CHEIRS database to capture this information for monthly reporting. January, 2005 Providers to send MCHB copies of randomly selected IFSP for quality review. During review of randomly selected records to be sent to MCHB – conduct follow up for records with "no reason" documented for late or no conference April, 2006 Five providers were at 100%. One provider was at 50% (FSS W. Hawaii). MCHB continues to work closer with this provider to offer additional support and they are working on stabilizing their staffing problems.	Overall compliance has not improved since July, 2005. 3 of 8 programs were less than 100% for the month of December for a total of 10 children not receiving transition conferences in a timely manner. February 2006 It was determined that programs required specific instructions regarding which screen to utilize when entering data. Even if there was no transition plan done due to family reasons, the data entry clerk is required to "create" a plan electronically in order to document that none was done due to "family reasons". June, 2006 Clarification with the W. Hawaii program regarding the definition of a transition conference continued during this month. The program reported that most of their conferences were with FSW and mother only. Therefore the program was corrected to not count these as transition conferences since no other agency/entity was present. The program should not count these routine IFSP meetings (which discuss options) as a transition conference.

Attachment E
Budget Charts, MAS 90 System
Fiscal Year 2006

Department of Health, Family Health Services Division, Maternal and Child Health Branch
Fiscal Year 2006 Actual Healthy Start Contract Expenditures by Service
(As of 10-31-2006)

Service	July 2005*	August 2005*	September 2005*	October 2005*	November 2005*	December 2005*	January 2006*	February 2006*	March 2006*	April 2006*	May 2006*	June 2006*	**Total FY 2006**
Early Identification	$155,469.78	$151,656.97	$157,687.39	$144,575.65	$142,064.92	$125,685.56	$149,599.50	$148,108.22	$169,005.86	$156,576.95	$159,061.43	$155,140.92	$1,814,633.15
Home Visiting	$982,324.26	$1,046,993.78	$1,022,293.67	$990,135.10	$951,381.54	$883,497.14	$842,673.43	$810,212.24	$922,371.42	$863,027.60	$892,426.00	$902,417.32	$11,109,753.50
Child Development Services	$82,364.06	$95,163.59	$107,210.13	$90,348.14	$84,720.25	$77,938.69	$72,730.21	$76,144.07	$84,075.18	$71,514.81	$71,338.47	$79,443.56	$992,991.16
Clinical Services	$64,390.23	$64,520.77	$66,301.93	$67,658.47	$66,669.35	$68,824.41	$61,845.07	$60,520.31	$61,077.72	$71,811.59	$65,420.65	$66,518.10	$785,558.60
Training	$0.00	$0.00	$0.00	$0.00	$0.00	$80,704.13	$11,269.11	$23,331.41	$23,337.59	$18,009.12	$20,123.88	$24,331.85	$201,107.09
Totals:	$1,284,548.33	$1,358,335.11	$1,353,493.12	$1,292,717.36	$1,244,836.06	$1,236,649.93	$1,138,117.32	$1,118,316.25	$1,259,867.77	$1,180,940.07	$1,208,370.43	$1,227,851.75	$14,904,043.50

	As of 10-31-2006	**As of 09-30-2006**	**As of 06-30-2006**	**As of 04-24-2006**	**As of 01-31-2006**	**As of 11-30-2005**	**As of 10-12-2005**
FY 2006 General Fund Appropriation:	$11,339,693.00	$11,339,693.00	$11,339,693.00	$11,339,693.00	$11,339,693.00	$11,339,693.00	$11,339,693.00
FY 2006 EIS Special Fund:	$2,000,000.00	$2,000,000.00	$2,000,000.00	$2,000,000.00	$2,000,000.00	$2,000,000.00	$2,000,000.00
FY 2005 General Fund Carry Over:	$342,502.30	$342,502.30	$342,502.30	$342,502.30	$342,502.30	$342,502.30	$342,502.30
FY 2005 Tobacco Fund Carry Over:	$814,084.21	$814,084.21	$814,084.21	$814,084.21	$814,084.21	$814,084.21	$814,084.21
Total Funds Available in FY 2006:	**$14,496,279.51**	**$14,496,279.51**	**$14,496,279.51**	**$14,496,279.51**	**$14,496,279.51**	**$14,496,279.51**	**$14,496,279.51**
Prior Years Exp. Paid with FY 2006 Funds:	($97,115.17)	($97,115.17)	($97,115.17)	($97,115.17)	($97,115.17)	($97,115.17)	($31,115.17)
Total Funds Available to Pay FY 2006 Services:	**$14,399,164.34**	**$14,399,164.34**	**$14,399,164.34**	**$14,399,164.34**	**$14,399,164.34**	**$14,399,164.34**	**$14,465,164.34**
Actual FY 2006 Expenditures:	($14,904,043.50)	($14,903,315.78)	($15,036,896.24)	($15,614,627.72)	($15,792,167.78)	($16,286,540.31)	($16,363,142.02)
****FY 2006 Surplus/(Deficit):**	**($504,879.16)**	**($504,151.44)**	**($637,731.90)**	**($1,215,463.38)**	**($1,393,003.44)**	**($1,887,375.97)**	**($1,897,977.68)**

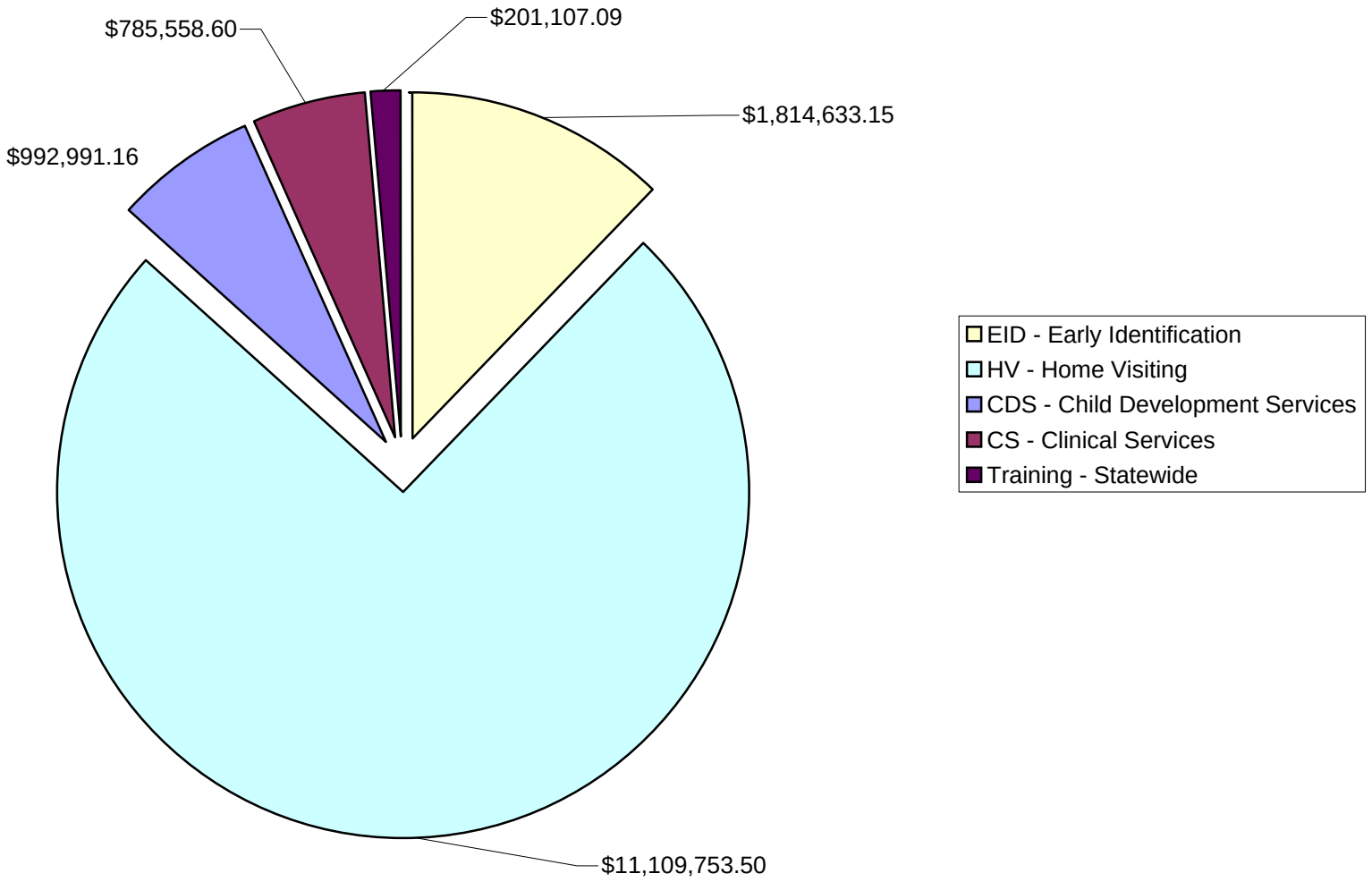
*Based on actual expenditures from MAS 90 software as of 10-31-2006.
**The EIS Special Fund ceiling increase of $1,000,000 will cover the $504,879.16 deficit.

Department of Health, Family Health Services Division, Maternal and Child Health Branch
Fiscal Year 2006 Summary of Projected Healthy Start Contract Expenditures by Service
(As of 10-31-2006)

Service	Amount
EID - Early Identification	$1,814,633.15
HV - Home Visiting	$11,109,753.50
CDS - Child Development Services	$992,991.16
CS - Clinical Services	$785,558.60
Training - Statewide	$201,107.09
Totals:	**$14,904,043.50**

*Report is based on MAS 90 Data as of 10-31-2006.

Department of Health, Family Health Services Division, Maternal and Child Health Branch
Fiscal Year 2006 Summary of Projected Healthy Start Contract Expenditures by Service
(As of 10-31-2006)



*Report is based on MAS 90 Data as of 10-31-2006.

Department of Health, Family Health Services Division, Maternal and Child Health Branch
Fiscal Year 2006 Healthy Start Contract Expenditure Report by Provider and Month
(As of 10-31-2006)

Provider	ASO Log	July 2005	August 2005	September 2005	October 2005	November 2005	December 2005	January 2006	February 2006	March 2006	April 2006	May 2006	June 2006	**Total FY 2006**
Catholic Charities	04-151	$54,295.43	$62,022.35	$65,070.02	$53,993.50	$60,990.72	$55,087.82	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$351,459.84**
CFS - EID	04-152	$107,399.90	$105,759.45	$105,710.36	$95,720.82	$99,140.90	$38,637.96	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$552,369.39**
CFS - Leeward	04-153	$114,129.52	$120,149.15	$137,613.54	$126,627.95	$102,186.53	$102,446.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$703,152.73**
CFS - Kauai	04-154	$66,227.12	$65,503.36	$54,494.63	$52,750.22	$62,226.56	$61,980.59	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$363,182.48**
MFSS - EID	04-155	$18,121.76	$16,686.24	$16,844.95	$16,922.16	$15,890.80	$17,957.81	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$102,423.72**
CFS - Waianae	04-156	$85,835.36	$98,025.78	$93,276.89	$89,267.62	$113,406.26	$98,887.25	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$578,699.16**
PACT	04-157	$101,411.88	$113,981.60	$102,728.62	$100,835.57	$86,279.93	$68,449.53	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$573,687.13**
MFSS - HV	04-158	$143,434.25	$135,480.64	$120,881.49	$152,010.25	$129,236.63	$115,572.79	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$796,616.05**
PPAS	04-159	$29,644.68	$33,049.02	$29,857.32	$30,050.39	$26,602.64	$23,219.43	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$172,423.48**
PATCH - Training	04-160	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$0.00**
CFS - Central	02-071	$84,631.00	$104,573.63	$120,015.27	$103,687.12	$109,430.13	$99,861.63	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$622,198.78**
FSS - West Hawaii	02-073	$84,910.36	$94,545.31	$116,734.22	$99,942.58	$87,590.46	$83,565.55	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$567,288.48**
PACT	02-079	$276,161.59	$281,592.90	$263,418.50	$254,206.99	$245,829.34	$233,609.44	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$1,554,818.76**
YWCA	02-080	$118,345.48	$126,965.68	$126,847.31	$116,702.19	$106,025.16	$119,136.28	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$714,022.10**
TIFFE - Training	06-116	$0.00	$0.00	$0.00	$0.00	$0.00	$80,704.13	$11,269.11	$23,331.41	$23,337.59	$18,009.12	$20,123.88	$24,331.85	**$201,107.09**
Catholic Charities	06-117	$0.00	$0.00	$0.00	$0.00	$0.00	$37,533.68	$135,267.94	$139,140.75	$169,679.15	$151,137.87	$158,504.02	$169,805.90	**$961,069.31**
CFS	06-118	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$344,038.42	$332,375.15	$360,182.20	$330,395.51	$318,836.83	$318,967.73	**$2,004,795.84**
FSS	06-119	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$84,969.93	$77,038.77	$95,110.36	$95,219.92	$107,768.55	$106,216.00	**$566,323.53**
MFSS	06-120	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$133,390.56	$147,242.85	$166,068.42	$154,277.16	$153,344.67	$146,986.07	**$901,309.73**
PACT	06-121	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$307,750.49	$274,895.26	$314,306.38	$309,876.77	$319,184.43	$326,909.39	**$1,852,922.72**
YWCA	06-122	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$121,430.87	$124,292.06	$131,183.67	$122,023.72	$130,608.05	$134,634.81	**$764,173.18**
	Totals:	**$1,284,548.33**	**$1,358,335.11**	**$1,353,493.12**	**$1,292,717.36**	**$1,244,836.06**	**$1,236,649.93**	**$1,138,117.32**	**$1,118,316.25**	**$1,259,867.77**	**$1,180,940.07**	**$1,208,370.43**	**$1,227,851.75**	**$14,904,043.50**

*Report is based on MAS 90 Data as of 10-31-2006.

Department of Health, Family Health Services Division, Maternal and Child Health Branch
Fiscal Year 2006 Healthy Start Contract Expenditure Report by Provider for EID - Early Identification
(As of 10-31-2006)

Provider	ASO Log	July 2005	August 2005	September 2005	October 2005	November 2005	December 2005	January 2006	February 2006	March 2006	April 2006	May 2006	June 2006	**Total FY 2006**
CFS - EID	04-152	$107,399.90	$105,759.45	$105,710.36	$95,720.82	$99,140.90	$38,637.96	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$552,369.39**
CFS - Kauai	04-154	$4,482.90	$3,202.27	$5,692.51	$6,082.85	$5,736.83	$8,448.64	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$33,646.00**
MFSS - EID	04-155	$18,121.76	$16,686.24	$16,844.95	$16,922.16	$15,890.80	$17,957.81	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$102,423.72**
PPAS	04-159	$887.43	$333.62	$740.64	$680.58	$0.00	$133.45	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$2,775.72**
FSS - West Hawaii	02-073	$11,005.65	$13,022.14	$15,290.27	$12,814.34	$10,369.86	$9,534.38	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$72,036.64**
YWCA	02-080	$13,572.14	$12,653.25	$13,408.66	$12,354.90	$10,926.53	$13,439.64	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$76,355.12**
Catholic Charities	06-117	$0.00	$0.00	$0.00	$0.00	$0.00	$37,533.68	$97,757.33	$101,183.61	$116,671.20	$103,375.02	$102,377.49	$104,224.79	**$663,123.12**
CFS	06-118	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$7,247.66	$7,697.57	$8,160.35	$7,912.04	$5,689.65	$6,920.23	**$43,627.50**
FSS	06-119	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$12,181.42	$8,723.21	$11,167.21	$12,790.99	$15,062.94	$11,045.21	**$70,970.98**
MFSS	06-120	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$19,987.65	$16,612.85	$19,509.31	$17,510.76	$19,750.78	$17,810.54	**$111,181.89**
YWCA	06-122	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$12,425.44	$13,890.98	$13,497.79	$14,988.14	$16,180.57	$15,140.15	**$86,123.07**
	Totals:	**$155,469.78**	**$151,656.97**	**$157,687.39**	**$144,575.65**	**$142,064.92**	**$125,685.56**	**$149,599.50**	**$148,108.22**	**$169,005.86**	**$156,576.95**	**$159,061.43**	**$155,140.92**	**$1,814,633.15**

*Report is based on MAS 90 Data as of 10-31-2006.

Department of Health, Family Health Services Division, Maternal and Child Health Branch
Fiscal Year 2006 Healthy Start Contract Expenditure Report by Provider for HV -Home Visiting
(As of 10-31-2006)

Provider	ASO Log	July 2005	August 2005	September 2005	October 2005	November 2005	December 2005	January 2006	February 2006	March 2006	April 2006	May 2006	June 2006	**Total FY 2006**
Catholic Charities	04-151	$46,277.81	$53,497.04	$58,197.29	$47,063.92	$53,112.40	$48,873.41	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$307,021.87**
CFS - Leeward	04-153	$95,935.35	$104,118.17	$119,110.85	$110,538.45	$96,890.54	$97,031.93	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$623,625.29**
CFS - Kauai	04-154	$56,374.55	$56,439.06	$40,157.76	$38,956.52	$46,555.86	$43,580.11	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$282,063.86**
CFS - Waianae	04-156	$80,408.23	$92,871.06	$87,935.47	$83,995.59	$98,027.16	$90,699.16	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$533,936.67**
PACT	04-157	$88,785.84	$98,208.11	$88,721.57	$87,034.67	$73,045.12	$57,959.01	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$493,754.32**
MFSS - HV	04-158	$123,777.87	$113,095.52	$98,965.08	$132,515.61	$108,782.43	$93,109.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$670,245.51**
PPAS	04-159	$23,273.39	$28,215.40	$24,250.82	$24,375.41	$22,102.64	$18,585.98	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$140,803.64**
CFS - Central	02-071	$79,278.03	$89,545.24	$98,127.03	$85,604.87	$91,657.80	$81,018.31	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$525,231.28**
FSS - West Hawaii	02-073	$66,161.57	$73,665.02	$90,386.22	$76,187.09	$69,236.61	$63,655.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$439,292.01**
PACT	02-079	$227,796.77	$235,749.70	$214,139.96	$210,528.36	$206,161.33	$194,814.37	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$1,289,190.49**
YWCA	02-080	$94,254.85	$101,589.46	$102,301.62	$93,334.61	$85,809.65	$94,170.36	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$571,460.55**
Catholic Charities	06-117	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$30,696.79	$31,039.90	$45,385.43	$40,522.01	$48,645.01	$55,556.22	**$251,845.36**
CFS	06-118	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$306,283.93	$283,497.40	$314,301.38	$272,038.66	$266,846.96	$265,295.04	**$1,708,263.37**
FSS	06-119	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$65,127.31	$61,336.57	$70,783.18	$74,804.38	$86,651.61	$84,318.79	**$443,021.84**
MFSS	06-120	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$93,999.37	$107,901.54	$124,064.56	$113,489.62	$113,641.88	$104,746.72	**$657,843.69**
PACT	06-121	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$249,768.90	$228,364.35	$261,247.87	$267,492.14	$274,389.02	$285,864.57	**$1,567,126.85**
YWCA	06-122	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$96,797.13	$98,072.48	$106,589.00	$94,680.79	$102,251.52	$106,635.98	**$605,026.90**
	Totals:	**$982,324.26**	**$1,046,993.78**	**$1,022,293.67**	**$990,135.10**	**$951,381.54**	**$883,497.14**	**$842,673.43**	**$810,212.24**	**$922,371.42**	**$863,027.60**	**$892,426.00**	**$902,417.32**	**$11,109,753.50**

*Report is based on MAS 90 Data as of 10-31-2006.

Department of Health, Family Health Services Division, Maternal and Child Health Branch
Fiscal Year 2006 Healthy Start Contract Expenditure Report by Provider for CDS - Child Development Services
(As of 10-31-2006)

Provider	ASO Log	July 2005	August 2005	September 2005	October 2005	November 2005	December 2005	January 2006	February 2006	March 2006	April 2006	May 2006	June 2006	**Total FY 2005**
Catholic Charities	04-151	$3,197.77	$3,506.28	$3,211.63	$1,599.89	$2,548.63	$647.66	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$14,711.86**
CFS - Leeward	04-153	$12,916.20	$10,871.86	$13,181.20	$10,817.47	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$47,786.73**
CFS - Kauai	04-154	$0.00	$803.89	$3,568.58	$2,716.24	$4,903.95	$4,818.91	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$16,811.57**
CFS - Waianae	04-156	$149.31	$0.00	$0.00	$0.00	$10,082.80	$2,773.59	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$13,005.70**
PACT	04-157	$6,751.04	$9,933.49	$8,029.05	$7,733.90	$7,167.81	$4,456.52	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$44,071.81**
MFSS - HV	04-158	$13,828.37	$16,427.42	$15,966.15	$13,420.98	$14,469.46	$16,303.83	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$90,416.21**
PPAS	04-159	$983.86	$0.00	$365.86	$494.40	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$1,844.12**
CFS - Central	02-071	$39.55	$9,845.98	$16,519.88	$12,765.91	$12,437.13	$13,393.30	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$65,001.75**
FSS - West Hawaii	02-073	$2,238.14	$1,355.15	$2,714.73	$2,679.15	$795.99	$1,750.67	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$11,533.83**
PACT	02-079	$37,271.82	$35,031.20	$38,135.54	$32,608.63	$28,471.01	$27,847.07	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$199,365.27**
YWCA	02-080	$4,988.00	$7,388.32	$5,517.51	$5,511.57	$3,843.47	$5,947.14	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$33,196.01**
Catholic Charities	06-117	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,479.74	$1,573.69	$2,141.74	$1,748.20	$1,497.04	$4,603.86	**$13,044.27**
CFS	06-118	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$8,988.68	$19,671.58	$15,691.75	$20,147.79	$22,589.63	$26,708.99	**$113,798.42**
FSS	06-119	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,836.20	$3,178.99	$9,493.97	$2,643.55	$0.00	$0.00	**$17,152.71**
MFSS	06-120	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$12,739.70	$15,382.62	$15,424.78	$14,712.22	$12,903.85	$17,209.94	**$88,373.11**
PACT	06-121	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$40,825.59	$29,406.91	$35,578.51	$25,502.63	$27,597.41	$24,162.82	**$183,073.87**
YWCA	06-122	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6,860.30	$6,930.28	$5,744.43	$6,760.42	$6,750.54	$6,757.95	**$39,803.92**
	Totals:	**$82,364.06**	**$95,163.59**	**$107,210.13**	**$90,348.14**	**$84,720.25**	**$77,938.69**	**$72,730.21**	**$76,144.07**	**$84,075.18**	**$71,514.81**	**$71,338.47**	**$79,443.56**	**$992,991.16**

*Report is based on MAS 90 Data as of 10-31-2006.

Department of Health, Family Health Services Division, Maternal and Child Health Branch
Fiscal Year 2006 Healthy Start Contract Expenditure Report by Provider for CS - Clinical Services
(As of 10-31-2006)

Provider	ASO Log	July 2005	August 2005	September 2005	October 2005	November 2005	December 2005	January 2006	February 2006	March 2006	April 2006	May 2006	June 2006	**Total FY 2005**
Catholic Charities	04-151	$4,819.85	$5,019.03	$3,661.10	$5,329.69	$5,329.69	$5,566.75	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$29,726.11**
CFS - Leeward	04-153	$5,277.97	$5,159.12	$5,321.49	$5,272.03	$5,295.99	$5,414.11	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$31,740.71**
CFS - Kauai	04-154	$5,369.67	$5,058.14	$5,075.78	$4,994.61	$5,029.92	$5,132.93	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$30,661.05**
CFS - Waianae	04-156	$5,277.82	$5,154.72	$5,341.42	$5,272.03	$5,296.30	$5,414.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$31,756.79**
PACT	04-157	$5,875.00	$5,840.00	$5,978.00	$6,067.00	$6,067.00	$6,034.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$35,861.00**
MFSS - HV	04-158	$5,828.01	$5,957.70	$5,950.26	$6,073.66	$5,984.74	$6,159.96	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$35,954.33**
PPAS	04-159	$4,500.00	$4,500.00	$4,500.00	$4,500.00	$4,500.00	$4,500.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$27,000.00**
CFS - Central	02-071	$5,313.42	$5,182.41	$5,368.36	$5,316.34	$5,335.20	$5,450.02	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$31,965.75**
FSS - West Hawaii	02-073	$5,505.00	$6,503.00	$8,343.00	$8,262.00	$7,188.00	$8,625.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$44,426.00**
PACT	02-079	$11,093.00	$10,812.00	$11,143.00	$11,070.00	$11,197.00	$10,948.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$66,263.00**
YWCA	02-080	$5,530.49	$5,334.65	$5,619.52	$5,501.11	$5,445.51	$5,579.14	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$33,010.42**
Catholic Charities	06-117	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5,334.08	$5,343.55	$5,480.78	$5,492.64	$5,984.48	$5,421.03	**$33,056.56**
CFS	06-118	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$21,518.15	$21,508.60	$22,028.72	$30,297.02	$23,710.59	$20,043.47	**$139,106.55**
FSS	06-119	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5,825.00	$3,800.00	$3,666.00	$4,981.00	$6,054.00	$10,852.00	**$35,178.00**
MFSS	06-120	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6,663.84	$7,345.84	$7,069.77	$8,564.56	$7,048.16	$7,218.87	**$43,911.04**
PACT	06-121	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17,156.00	$17,124.00	$17,480.00	$16,882.00	$17,198.00	$16,882.00	**$102,722.00**
YWCA	06-122	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5,348.00	$5,398.32	$5,352.45	$5,594.37	$5,425.42	$6,100.73	**$33,219.29**
	Totals:	**$64,390.23**	**$64,520.77**	**$66,301.93**	**$67,658.47**	**$66,669.35**	**$68,824.41**	**$61,845.07**	**$60,520.31**	**$61,077.72**	**$71,811.59**	**$65,420.65**	**$66,518.10**	**$785,558.60**

*Report is based on MAS 90 Data as of 10-31-2006.

Department of Health, Family Health Services Division, Maternal and Child Health Branch
Fiscal Year 2006 Healthy Start Contract Expenditure Report by Provider for Training - Statewide
(As of 10-31-2006)

Provider	ASO Log	July 2005	August 2005	September 2005	October 2005	November 2005	December 2005	January 2006	February 2006	March 2006	April 2006	May 2006	June 2006	**Total FY 2006**
TIFFE - Training	06-116	$0.00	$0.00	$0.00	$0.00	$0.00	$80,704.13	$11,269.11	$23,331.41	$23,337.59	$18,009.12	$20,123.88	$24,331.85	**$201,107.09**
	Totals:	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$80,704.13**	**$11,269.11**	**$23,331.41**	**$23,337.59**	**$18,009.12**	**$20,123.88**	**$24,331.85**	**$201,107.09**

*Report is based on MAS 90 Data as of 10-31-2006.

Attachment E
Budget Charts, MAS 90 System
Fiscal Year 2007

Department of Health, Family Health Services Division, Maternal and Child Health Branch
Fiscal Year 2007 Actual Healthy Start Contract Expenditures by Service
(As of 10-31-2006)

Service	July 2006*	August 2006*	September 2006*	**Total FY 2007**
Early Identification	$162,925.83	$184,812.13	$176,000.75	$523,738.71
Home Visiting	$832,694.88	$953,230.41	$918,640.01	$2,704,565.30
Child Development Services	$51,716.23	$69,496.81	$69,724.89	$190,937.93
Clinical Services	$62,314.82	$51,426.44	$58,934.63	$172,675.89
Training	$22,479.63	$11,996.19	$18,488.41	$52,964.23
Totals:	$1,132,131.39	$1,270,961.98	$1,241,788.69	$3,644,882.06

*Based on actual expenditures from MAS 90 software as of 10-31-2006.

Attachment F
Training

Family Violence
Substance Abuse Basics
Advanced Substance Abuse
Foundation Training: Dynamics of Child Abuse and Neglect
Foundation Training: Introduction to Nurturing Fathers
Foundation Training (Child Abuse and Neglect, Introduction to Early Intervention, and Nurturing Fathers)
Mental Health
Maternal Family Health
Nurturing Principles and Practices
Cultural Sensitivity
Culturally Relevant Programs for Families
Early Childhood Basics
Advanced Childhood Development
Working with Teens
Boundaries and Ethics
Family Support Worker Role Specific Training
Administering the ASQ
Clinical Supervision
Creating an Effective IFSP

Attachment F
Training Schedule

Dates of Training	Training Topic	Number of Participants
10/11 – 10/12/05	Foundation Training: Healthy Start delivery system for the Prevention of Child Abuse & Neglect -Dynamics of Child Abuse & Neglect -Introduction to Early Intervention Services -Nurturing Fathers Program	9
10/25 – 10/26/05	Foundation Training	26
10/31 – 11/4/05	Core Training: Family Support Worker/Supervisor	14
11/7 – 11/8/05	Foundation Training	27
11/28 – 12/1/05	Core Training: Family Support Worker/Supervisor	16
12/5 – 12/9/05	Core Training: EID Worker/Supervisor	13
12/7 – 12/8/05	Foundation Training	34
1/24 – 1/25/06	Foundation Training	8
1/26 – 1/27/06	Early Childhood Basics: -Overview of Development -Baby Care Basics -Baby Health & Safety	12
1/31/06	Culturally Relevant Programs for Families: -6 Guidelines to Creating culturally relevant services	8
2/10/06	Maternal & Family Health: -Family Planning/Nutrition -Post Partum Depression	19
2/15/06	Nurturing Principles & Practices: -Discipline/Punishment/Behavior -Spanking/Choices/ASK	15
2/17/06	Family Violence: -Domestic Violence/Relationships/Kids -DV and Trauma	13
2/27 – 3/3/06	Core Training: Family Support Worker/Supervisor	17
3/21/06	Substance Abuse Basics: -Home Visitor Role -Interventions/Applications	13
3/24/06	Administering the ASQ: -Overview of ASQ & calculations -Score and overall section -ASQ-SE	13
3/28/06	Clinical Supervision: -Employee Selection -Supervisors “Home Visitor” Model	6
3/31/06	Mental Health: -Defining Mental Health -Paradigms of MH and Psychopathology -Functional Social-Emotional Development	15

Attachment F
Training Schedule

4/4/06	Boundaries & Ethics: -Personal Safety -Defining Ethics -Setting Personal/Professional Boundaries	21
4/19/06	Advanced Substance Abuse: -Signs & Symptoms -Categories & Effects -Resources	14
5/1 – 5/5/06	Core Training: Family Support Worker/Supervisor	13
5/9 – 5/10/06	Foundation Training	16
5/11 –5/12/06	Early Childhood Basics	9
5/16/06	Working with Teens -Brain Development -Understanding Adolescents -Case Study and Resources	22
5/25 –5/26/06	Advanced Child Development: -Development (0-12 months) -Development (12 – 36 months)	5
5/30/06	Boundaries & Ethics	10
6/2/06	Maternal & Family Health	7
6/10 –6/11/06	Core Training: Family Assessment Worker	13
6/6/06	Culturally Relevant Programs for Families	13
6/16/06	Administering the ASQ	17
6/27 –7/3/06	Core Training: Family Support Worker/Supervisor	12