Hawaii State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Promote reproductive life planning with a focus on underserved populations	By July 2025, increase the percentage of women ages 18 through 44 who had a preventive medical visit in the past year to 87%	Promote women's wellness through systems building efforts Promote pre/inter-conception health care visits Provide reproductive health services for areas with limited access and/or shortage of care, including rural communities	***Inactive -*** *ESM WWV.1 - Percent of births with less than 18 months spacing between birth and next conception* ESM WWV.2 - The number of women aged 18-44 years served through the state MCH reproductive health and wellness program.	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

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					NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression,

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					Formerly NOM 24) - PPD
Improving maternal care including postpartum care for pregnant people	• By July 2025, increase the percent of women who attended a postpartum checkup within 12 weeks after giving birth to 94%. • By July 2025, increase the percent of women who attended a postpartum checkup and received recommended care components to 82%.	Define the maternal care health issue by completing a mixed method review of relevant data, with a specific focus on disparities that include race/ethnicity data and geographic location. Review the evidence-based literature, emerging best practices, and expert opinion resources on current postpartum care practices, in order to identify specific strategies to improve postpartum health outcomes and maternal well-being.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Increase the rate of infants sleeping in safe conditions	By July 2025, increase the percent of infants placed to sleep on their backs to 86% By July 2025, increase the percent of infants placed to sleep on a separate approved sleep surface to 23% By July 2025, increase the percent of infants placed to sleep without soft objects or loose bedding to 35%	Build diversity and reach of Safe Sleep Hawaii through increased community partnerships to promote health equity Increase awareness of the importance of Safe Sleep and provide safe sleep education, including public service announcements and digital media	***Inactive -*** *ESM SS.1 - The number of languages in which safe sleep educational materials are available for Hawaii's communities.* ESM SS.2 - The number of translated Safe Sleep Guides for Parents that were provided to the agencies, organizations and individuals, on request	NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID
Reduce food insecurity for pregnant women and infants through WIC program	By 2025, increase the total number of WIC participants in Hawaii to 30,000	Partner with agency and community programs to to improve WIC enrollment and utilization Improve data collection and analysis to identify key barriers to WIC benefit utilization and enrollments		SPM 2: Reduce the rate of food insecurity for pregnant women and infants through the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	

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promotion and partnerships				services	
Child Health					
Improve the percentage of children screened early and continuously ages 0-5 years for developmental delay	By July 2025, increase the percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year to 42.0%	Develop and improve services infrastructure to better coordinate developmental screening efforts Improve developmental screening data Build the capacity of the Hi'ilei program to increase developmental screening and referral efforts for young children	***Inactive -*** *ESM DS.1 - Develop and implement Policy and Public Health Coordination rating scale to monitor developmental screening efforts around the areas of systems development, family engagement, data integration, and addressing vulnerable populations* ESM DS.2 - The number of children screened through the Hi'ilei Developmental Screening Program using a standardized screening tool.	NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS	NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Reduce the rate of confirmed child abuse and neglect cases per 1,000 with special attention to children ages 0-5 years.	By July 2025, reduce the rate of confirmed child abuse and neglect cases per 1,000 for children to 4.8 per 1,000	Support the collaboration and integration of family strengthening and child maltreatment prevention programs and activities across federal, state, local and private programs, and organizations Provide training and technical assistance to community-based, prevention programs to strengthen families and prevent child abuse and neglect Promote health equity by addressing disparities in confirmed CAN cases		SPM 1: Rate of confirmed child abuse and neglect reports per 1,000 for children ages 0 to 5 years.	

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Improving access to medical homes for all children including children with special health care needs.	By July 2025, increase the percent of all children, ages 0-17, who have a medical home to 46.6%.	Define the issues around the pediatric medical home by implementing a mixed method review of all available data on this population, with a focus on disparities including race/ethnicity. Review the evidence based literature, emerging best practices, and expert opinion to identify pediatric medical home care strategies to improve medical home establishment and related care.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Adolescent Health					
Improve the healthy development, health, safety, and well-being of adolescents	By July 2025, increase the percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year to 86%	Collaboration. Develop partnerships with community health and youth service providers to promote adolescent health and annual wellness visits Engagement. Work with adolescents and youth service providers to develop and disseminate informational resources to promote access to adolescent preventive health services Workforce Development. Provide resources, training, and learning opportunities for youth service providers and community health workers to promote adolescent health and wellness visits	ESM AWV.1 - Develop and disseminate a teen-centered Adolescent Informational Resource (AIR) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits	NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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					(Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly

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					NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Children with Special Health Care Needs					
Improve the percentage of youth with special health care needs ages 12-21 years who receive services necessary to make transitions to adult health care	By July 2025, increase the percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care to 27%	Incorporate transition planning and care coordination into the Children and Youth with Special Health Needs Section to serve enrolled youth and their families.. Provide education and public awareness on transition to adult health care for children/youth with and without special health care needs, and promote the incorporation of transition into planning and practices, in collaboration with state and community partners. Develop and expand efforts to address health disparities in transition services for youth	ESM TR.1 - Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult health care for Youth with Special Health Care Needs (YSHCN), related to Six Core Elements of Health Care Transition 2.0.	NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC
Improving access to medical homes for all children including children with special health care needs.	By July 2025, increase the percent of children with special health needs, ages 0-17, who have a medical home to 43.1%.	Define the issues around the pediatric medical home for CSHN by implementing a mixed method review of all available data on this population, with a focus on disparities including race/ethnicity. Review existing evidence-based literature, emerging best practices, and expert opinion resources to identify CSHN strategies to improve medical home establishment and related care.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Cross-Cutting/Systems Building					
Address health equity and disparities by expanding	By July 2025, provide training and support services on pediatric mental health care to 80 pediatric and/or mental health care	Refine, develop and implement pediatric mental health care access model Promote workforce development and training on pediatric mental health care		SPM 3: The number of pediatric and/or behavioral health providers receiving training and support	

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pediatric mental health access in rural and under-served communities	providers in underserved communities statewide.	Support services and linkages in communities		services on pediatric mental health care in underserved communities/counties statewide.	