

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

Hawaii

**FY 2022 Application/
FY 2020 Annual Report**

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I. General Requirements

I.A. Letter of Transmittal

DAVID Y. IGE
GOVERNOR OF HAWAII



ELIZABETH A. CHAR, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:
File:

August 27, 2021

Michael D. Warren, M.D., M.P.H., FAAP
Associate Administrator
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, 18W
Rockville, Maryland 20857

Dear Dr. Warren:

The State of Hawaii wishes to formally apply to the Maternal and Child Health Bureau for continued funding under the Maternal and Child Health Services, Title V Block Grant Program for fiscal year (FY) 2022 (October 1, 2021 – September 30, 2022). The FY 2022 application and FY 2020 annual report is submitted via the Health Resources and Services Administration Electronic Handbooks (EHBs).

Please note that the Title V grant proposal guidance states that a signed copy of the application face sheet, Standard Form 424, is no longer required. Therefore, this document will also be submitted electronically through the EHBs.

If you have any questions, please contact Annette Mente at (808) 733-8358 or email at annette.mente@doh.hawaii.gov.

Sincerely,

A handwritten signature in blue ink, appearing to read "Elizabeth A. Char".

Elizabeth A. Char, M.D.
Director of Health

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January 31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Hawaii is the only island state in the U.S., comprised of seven populated islands organized into four major counties: Hawaii, Maui, Honolulu (Oahu), and Kauai. Spanning nearly 11,000 square miles with a land mass of 6,422 square miles, the state is home to 1.4 million residents with 70% living in Honolulu, the most populous county.



Hawaii is one of the most ethnically diverse states with no single majority race (38% Asian, 25% White, 10% Native Hawaiian/Pacific Islander, 2% Black). Nearly 23% of the population is mixed race with Native Hawaiians comprising 6.1% of the population. Also, about 18.7% of all residents are immigrants—mostly from Asia and the Pacific.

The state government is responsible for functions usually performed by counties or cities in other states. Hawaii is the only state, for example, with a single unified public school system. Similarly, Hawaii has no local health departments but has county health offices on the 'neighbor islands' to assure services statewide.

The Hawaii State Department of Health (DOH) works to protect and improve the health and environment for all people in the state. The DOH Family Health Services Division (FHSD) uses the federal Title V Maternal and Child Health Block Grant (Title V) to improve the health of women, infants, and children, including those with special healthcare needs. FHSD works to promote health equity and uses both life course and multi-generational approaches. To expand its capacity and reach to address population needs, FHSD leverages state and federal grant funds and community partnerships.

Hawaii identified eight priorities for 2016-2020 based on the 2015 needs assessment spanning the six Title V population domains.

Domain	State Priority Need
Women's/Maternal Health	Promote reproductive life planning
Perinatal/Infant Health	Increase the rate of breastfeeding
	Increase the rate of infants sleeping in safe conditions
Child Health	Improve the percentage of children age 0-5 years screened early and continuously for developmental delay
	Reduce the rate of child abuse and neglect, with special attention to children ages 0-5 years
	Improve the oral health of children
Adolescent Health	Improve the healthy development, health, safety, and well-being of adolescents
Children with Special Health Care Needs	Improve the percentage of youth with special health care needs ages 14-21 years who receive services necessary to make transitions to adult healthcare
Cross-Cutting	Expand Telehealth across Title V programs

Ongoing Needs Assessment: COVID in Hawaii

The 2020 5-year Title V needs assessment was completed in January 2020 prior to the Novel Coronavirus Disease 2019 (COVID-19) pandemic. A brief overview of the pandemic in Hawaii and its impacts follows.

Hawaii managed the COVID-19 pandemic better than many other states. This reflects Hawaii's ability to place restrictions on travel early in the pandemic and the State's close adherence to federal safety guidelines and recommendations.

Policy: Governor David Ige acted swiftly issuing the first of 21 COVID-related emergency proclamations on March 4, 2020, at the first signs of travel-related cases, preceding the federal government's response to the pandemic on March 13. The governor's proclamation directed the State and counties to implement a mandatory stay-at-home order; self-quarantine for all persons entering the state and traveling between counties; limited non-essential business, restaurants and bars, and

gatherings; and mandated safe practices including mask wearing and physical distancing to reduce the spread of COVID-19. The State also implemented active COVID-19 testing and contact tracing. County proclamations followed with added restrictions based on disease levels in coordination with the State.

Course of the Disease: The actions by state and county officials throughout 2020 resulted in limited cases and the lowest number of deaths in the U.S. In 2020, Hawaii suffered a case spike during the summer that delayed loosening of out-of-state travel restrictions until late September. After another smaller December holiday increase, virus numbers trended downward until a recent July 2021 spike due to the Delta variant. Overall, COVID-19 cases and deaths were minimized. The state reported a cumulative 36,250 COVID-19 cases statewide and 508 deaths as of June 26, 2021. Hawaii's cumulative death rate of 38/100,000 has been the lowest in the country. Like most states, initial deaths were largely confined to the elderly; however, Hawaii was largely successful in limiting outbreaks at long-term care (LTC) and congregate settings. Dramatic disparities were seen with Native Hawaiian, Filipino, and Pacific Islanders experiencing higher rates of infection and death. Since December, Hawaii is among the states furthest along in vaccination, priming the state's economic recovery.

Economic Impact: Disruptions from the pandemic resulted in a 98.8% decrease in travelers to the state in April 2020. Hawaii's unemployment rate was the highest in the country at 22% in April 2020; it has improved as the economy slowly reopened, but still remains high at 8.0%. The most vulnerable in our communities were most impacted by unemployment. Food banks in the state reported serving 60% more people than prior to the pandemic. Enrollments for government assistance soared: a 50% increase in SNAP food assistance and 28% increase in Medicaid from April 2020 to March 2021. Schools transitioned to distance learning and those without access to internet or Wi-Fi were left with limited or no access to educational, health, or social resources.

Recovery: The economy has made steady improvements in 2021 fueled by a tourism industry rebound, with visitor arrivals at almost 90% of 2019 levels. However, job recovery continues to lag by 40%. An unprecedented level of federal spending also provided essential support for the state economy. Direct aid to state and local governments offset a significant fraction of budget shortfalls. Housing insecurity threatened many families but were helped by the federal eviction moratorium and assistance to renters and homeowners. Rents, which fell in 2020, have turned upward in 2021, and home prices have continued to reach record highs. Since its low in April 2020, economists estimate Hawaii's recovery to be 75% of its pre-pandemic status.

Response: The Department of Health worked tirelessly to protect and inform the public about prevention, treatment, and resources for those experiencing hardship. Materials, PSAs, and media releases included translations in languages of vulnerable communities and culturally tailored messaging. DOH efforts were closely scrutinized, lauded and criticized at times by the public and elected officials. In September 2020, DOH leadership changed with the appointment of Dr. Elizabeth Char as director. Title V nursing staff were deployed to assist directly with COVID disease control efforts.

Title V Programs/Services: In 2020, Title V programs as reported in Form 5a saw a 3.8% reduction in direct client services as in-person client visits moved to telehealth and family concerns switched to immediate COVID-related needs. However, client outreach efforts in 2020 reflect a 300% increase over 2019 as FHSD launched more media initiatives to provide critical updates on service availability and health messaging to help families cope with the stressors of the COVID lockdowns. Most Title V program staff moved to telework in 2020. While most programs reported a general increase in partnership collaboration, family engagement efforts proved more challenging during the pandemic.

5-Year Plan Changes for 2021-2025 (FY 2021)

Given the consequences of the pandemic, the Title V priorities were reassessed in FY 2021 and changes made. Three priorities/performance measures will be retired:

- Children's Oral Health
- Telehealth expansion among Title V programs
- Breastfeeding (deleted in FY 2021)

Four new state priorities were added in FY 2021 as a result of pandemic impacts and new federal funding opportunities. All four priorities address health equity.

- Food Insecurity through WIC services
- Telehealth expansion to underserved communities
- Pediatric Mental Health
- Child Wellness Visits/Immunizations

Health Equity: Hawaii also integrated a health equity strategy into the plans for any Title V priorities without an existing equity component. Activities for the new equity strategies were selected from AMCHP conference presentations and guidance from the MCH Evidence Center.

Other Plan Changes: Many planned FY 2020 activities were delayed/postponed due to COVID. Several priority strategies, activities, and measures were revised in the 5-year plan in response to ever-changing pandemic circumstance/conditions in partnership with community stakeholders. All programs continue ongoing assessment activities to engage stakeholders, families, and youth through the ever-changing pandemic environment.

5-Year Plan (2016-2020): Key Accomplishments

FY 2020 marks the last year of the Title V 5-year project period. This year's report provides an opportunity to highlight two to three key accomplishments achieved during the plan period by domain and priority.

DOMAIN: WOMEN'S/MATERNAL HEALTH

Promote reproductive life planning

- Implemented two evidence-based strategies from the MCH Bureau Infant Mortality Learning Collaborative that improve access to healthcare and reproductive decision-making: promote use of the One Key Question® (OKQ) screening approach and increase accessibility to Long-Acting Reversible Contraception (LARC).
- Medicaid provider policies promoted use of OKQ by eliminating prior approval to expand contraception coverage and allow for one-year contraception prescriptions, unbundling LARC from delivery charges and hospital stocking.
- Trained over 1,000 healthcare and service providers in OKQ curriculum and most Hawaii birthing hospitals now stock LARC for same day access.

DOMAIN: PERINATAL/INFANT HEALTH

Promote breastfeeding

- Completed and continued implementation of the State Breastfeeding Plan.
- Expanded WIC community-based provider network to increase service availability and access expertise to reach underserved, high-risk populations.
- Provided updated breastfeeding and COVID-19 information during the pandemic for community responders, healthcare workers, and the public.

Promote safe sleep practices

- Promoted adoption of safe sleep policies, protocols, and guidelines following the AAP standards by all the state's 12 birthing hospitals.
- Policy adoption for mandated annual safe sleep training for all state licensed childcare providers and partnered to develop training/educational materials now used widely by programs/agencies serving families with newborns/young children.
- Partnered with the State Child Care Program and Office of Language Access to translate SS educational materials into 11 languages to broaden outreach efforts to high-risk groups.

DOMAIN: CHILD HEALTH

Improve early and continuous screening for developmental delay

- Completed and continue to disseminate standard guidelines for developmental screening with statewide stakeholders for all programs working with young children.
- Integrated development screening into all state early childhood plans and working collaboratives.
- Established systematic developmental screening data sharing among Title V early childhood programs to assure screening, referral, and follow-up services.
- Established a community-based model for development screening, referrals, and supports for children in Maui County funded by the Early Childhood Comprehensive Systems (ECCS) Impact grant.
- Received Centers for Disease Control funding to partner with Hawaii's pediatric Act Early Ambassador to promote development screening.

Improve the oral health of children

- Completed the CDC state oral health infrastructure grant, including development of data surveillance plan and

publications and completion of the first basic screening surveys of third grade students and Head Start enrollees.

- Rebuilding of the State Oral Health Coalition with formal organizational structure, fiscal agent, and working subcommittees. During the early days of the pandemic, shared critical information on safety protocols and avenues to secure PPE served as a hub to coordinate bulk PPE purchasing and hosted workforce trainings.

Reduce the rate of child abuse and neglect (CAN)

- Forged critical partnerships to promote evidence-based prevention practices and collaboration among the State's Child Welfare Services (CWS), Judiciary, Department of Education (DOE), and community service providers. Completed the CWS five-year Service Plan with a focus to *prevent* children from entering the foster care system.
- Supported statewide efforts to increase awareness about adverse childhood experiences and promote trauma-informed care models of practice.
- Maintained MIECHV evidence-based services to at-risk families.

DOMAIN: ADOLESCENT HEALTH

Improve adolescent health and well-being

- Partnered with the Coalition for Drug-Free Hawaii youth network to create a youth-designed Adolescent Resource Toolkit (ART) available via the TeenLink Hawaii website and supported by media campaign using popular social media 'influencers.'
- Integrated adolescent health information and promotion of annual wellness visits into the federal Personal Responsibility and Education Program (PREP) evidence-based teen pregnancy prevention program serving high-risk youth, including workforce training with youth service providers.

DOMAIN: CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

Improve transitions to adult healthcare

- Developed a system for transition planning for enrolled Children and Youth with Special Health Needs Section youth using the evidence-based Six Core Elements of Health Care Transition, including guidelines, educational tools, workbook, and database tracking. The system model is being adopted by Kaiser Permanente Hawaii for adolescent services.
- Supported development of an active statewide network of agency/community partners that promote transition services, including the state DOE, Vocational Rehab, and family service organizations through popular in-person events. Many programs were postponed or switched to virtual events in 2020.

DOMAIN: CROSS-CUTTING/SYSTEMS BUILDING

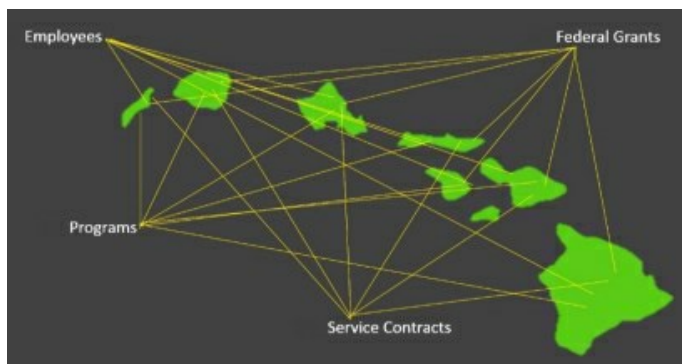
Promote telehealth throughout Title V programs

- Led by the Genetics program, provided equipment, software, and training to support use of Zoom across FHSD programs, which laid the foundation for a smooth transition to telehealth/telework during the COVID pandemic. Early in the pandemic, telehealth educational videos/trainings were developed for healthcare providers and families, which were used by HRSA nationally to promote use of telehealth.
- Established Project ECHO Hawaii with the Area Health Education Center to use videoconferencing to build healthcare workforce capacity to improve patient access to specialty healthcare in rural communities.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

FHSD provides all levels of service delivery: direct, enabling, and infrastructure building. FHSD's reach is statewide with no local health departments. One of the largest Divisions in DOH, FHSD is comprised of three branches—Maternal and Child Health (MCH); Children with Special Health Needs (CSHN); and Women, Infants and Children (WIC) Services. Together, the division administers 30 programs, 21 federal grants, and approximately 150 service contracts with community-based organizations totaling roughly \$50million—all with 283 FTE positions statewide.

Title V funds play a critical role in supporting the state's overall MCH efforts. In 2020, the FHSD budget was \$93.1 million. Nearly \$2.1 million was provided by Title V, with \$45.3 million state matching funds and an additional \$45.8 million in other federal funds. Of the state's overall population, FHSD programs reached an estimated 99% of pregnant women; 99% of all infants; 18% of children 1-21 years of age; 19% of children with special health needs; and 4% of others (general adult population).



Title V funds are used for key program capacity and public health infrastructure positions needed to administer MCH programs statewide (19.3 FTE). Positions include: critical data analytics staff (epidemiologists and research statisticians); administrative, fiscal and program management for MCH and CSHN; Public Information Officer; nutritionist and audiologist (CSHN). These positions are critical to: 1) securing, leveraging, and managing a broad array of funding sources; 2) addressing statewide surveillance needs; 3) developing critical statewide partnerships and system-building efforts; 4) improving quality to assure services are family


centered, culturally relevant, and community based; 5) assuring a statewide system of care through provision of safety-net and gap-filling services; 6) recruiting and supporting workforce needs; and 7) assuring development/dissemination of public health messaging.

At the start of the COVID-19 pandemic in March 2020, the Family Health Services Division (FHSD) hired an Information Specialist, which is funded by FHSD's Title V MCH Block Grant. While an overall communications plan is being developed to support Title V programs, one of the main overarching objectives is to increase awareness of these programs among Hawaii's MCH population through paid and earned media with a focus on TV, radio, and digital.

For the public awareness campaign, two 30-second TV spots were produced featuring top Hawaii comedian and social media influencer Tumua Tuinei. The former University of Hawaii football player brought his brand of character comedy to the PSAs, depicting both a teen and parents, highlighting the importance of communication and directing viewers to the TLH website. The PSAs, which were reformatted for radio and digital media, used humor as an entry point to open up teens and adults to the resiliency messaging.



As the campaign is still running, the reach via broadcast TV is projected to be 98.9% of the target audience of households with children, with a frequency of 13. Combined broadcast and cable TV impressions will be more than 2.1 million.

teenLink!  Take Care of Your **BODY**
Learn More

display, pre-roll, streaming TV, and social media. Digital ads will result in nearly 2 million impressions.

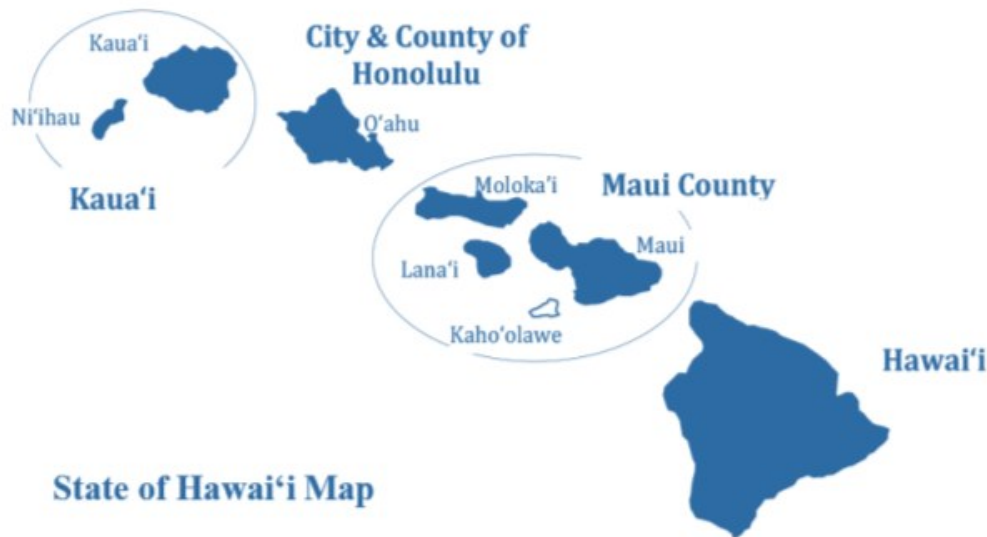


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III.B. Overview of the State

GEOGRAPHY

Hawaii is situated almost in the center of the Pacific Ocean and is one of the most isolated yet populous places on Earth. The west coast of North America is 2,400 miles from Honolulu, roughly a 5-hour flight by air. Five time zones separate Hawaii from the eastern U.S. Nationally, Hawaii is the 11th smallest state by population size and 4th smallest by land area.



The state is composed of seven populated islands in four major counties: Hawaii, Maui, Oahu, and Kauai. The county is the lowest civil subdivision in the state. As a result, counties in Hawaii provide some services, such as fire and police protection, that in other states are performed by cities or towns. Counties also elect a mayor and council. Likewise, the state government is responsible for functions usually performed by counties or cities in other states. Hawaii is the only state, for example, with a single unified public-school system. Similarly, Hawaii has no local health departments but has district health offices for each of the three neighbor island counties.

Approximately 70% of the state population resides in the City and County of Honolulu on the island of Oahu, concentrated in the Honolulu metropolitan area. The neighbor island counties are Hawaii, Kauai (includes Niihau, which is privately owned with restricted access) and Maui (includes Molokai, Lanai, and Kahoolawe, which is unpopulated).

Only 10% of the state's total land area is classified as urban. The City and County of Honolulu is the most urbanized with a third of its land area and 96% of its population in urban communities. Most tertiary healthcare facilities, specialty and subspecialty services, and healthcare providers are located on Oahu. Consequently, neighbor island and rural Oahu residents often travel to Honolulu for these services. Interisland passenger travel to and from Oahu is entirely by air. Air flights are frequent but comparatively expensive. Airfare costs can be quite volatile based on varying fuel costs. This creates a financial barrier for neighbor island residents since roundtrip airfare costs range from \$130 to over \$200.

Geographic access is further limited because public transportation is inadequate in many areas of the state except for the Honolulu metropolitan area. Over the past five years, the islands of Maui, Kauai, and Hawaii have established limited public bus service, but their use by residents is largely sporadic. Residents in rural communities, especially on the neighbor islands, rely on automobiles to travel to major population centers on their island where healthcare

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

DEMOGRAPHICS

The estimated 2019 state population is 1,415,872 residents, the 30th most populous state in the U.S. Oahu is home of 69.0% (980,080 residents) of the state's population, while 14.2% (201,513 residents) live on the Hawaii Island, 11.8% (167,488 residents) in Maui County, and 5.1% (72,293 residents) in Kauai County. Compared to 2018 (1,420,491), there was a 4,619 (0.3%) population decline in the state.

ETHNIC DIVERSITY

Hawaii is one of the most ethnically diverse states in the U.S. with no single race majority. According to the 2019 American Community Survey (ACS), 22.3% of the population reported two or more races and the following single race proportions: White=24.1%; Asian=38.7%; and Native Hawaiian or Other Pacific Islander (NHOPI)=10.8%. The largest Asian single race subgroups were Filipino (15.7%) and Japanese (12.2%) and the largest NHOPI single race subgroup was Native Hawaiian (6.4%). The individual Asian and NHOPI subgroups are listed in the table below and show the heterogeneity of these aggregated race groupings.

Table: Asian and Native Hawaiian or Other Pacific Islander Race Groupings Detail, 2010 Census

Race Group		Detailed Subgroup
Asian		Filipino
		Japanese
		Chinese
		Korean
		Vietnamese
		Asian Indian
		Thai
		Laotian
		Taiwanese
		Cambodian
		Indonesian
Native Hawaiian or Other Pacific Islander	Polynesian	Native Hawaiian
		Samoan
		Tongan
		Tokelauan
		Tahitian
	Micronesian	Guamanian or Chamorro
		Marshallese
		Kosraean
		Chuukese
		Palauan
		Yapese
		Saipanese
		I-Kiribati
	Melanesian	Fijian
		Papua New Guinean
		Ni-Vanuatu
		Solomon Islander

Sources: US Census Bureau. The Asian Population: 2010. 2010 Census Briefs. Issued March 2012; C2010BR-11.

US Census Bureau. The Native Hawaiian and Other Pacific Islander Population: 2010. 2010 Census Briefs. Issues May 2012; C2010BRF-12

Table: Total Numbers within Selected Race Groupings by Alone and Alone or in Combination status, Percent of State Population and Percent Reporting at least one Other Race, Hawaii, American Community Survey.

Race Group	Resident Population in the State of Hawaii (N)	Percent of State Population (%)	Proportion Reporting at least one other Race (5)
White Alone	341,211	24.1%	0
White Alone or in Combination	582,436	41.1%	41.5%
Native Hawaiian or Other Pacific Islander (NHOPI) Alone	152,601	10.8%	0
NHOPI Alone or in Combination	354,987	25.1%	56.9%
<i>Native Hawaiian Alone</i>	90,070	6.4%	0
<i>Native Hawaiian Alone or in Combination</i>	284,996	20.1%	65.9%
Asian Alone	547,843	38.7%	0
Asian Alone or in Combination	801,987	56.6%	31.7%
<i>Filipino Alone</i>	221,724	15.7%	0
<i>Filipino Alone or in Combination</i>	371,528	26.2%	33.6%
<i>Japanese Alone</i>	172,049	12.2%	0
<i>Japanese Alone or in Combination</i>	306,129	21.6%	31.3%
<i>Chinese Alone</i>	81,209	5.7%	0
<i>Chinese Alone or in Combination</i>	203,531	14.4%	60.0%
Source: U.S. Census Bureau. 2019. American Community Survey Calculations by Hawaii Department of Health, Family Health Services Division			

Those that report two or more race groups are not included in the single race groups commonly reported. Due to the large proportion with more than one race, recommendations are to report race as “Alone” or “Alone or in Combination” with another group. For example, Native Hawaiian accounted for 25.1% of the state population when reported as “Alone or in Combination,” compared to just 6.4% when Native Hawaiian is reported singly. There is also variation among race subgroups with an overall estimate of 31.7% of those in the “Asian Alone or in Combination” reporting another race but variation in the three largest subgroups range from 33.6% in Filipino to 60.0% in Chinese. The other Asian subgroups are likely newer immigrants to Hawaii compared to these three and have smaller numbers reporting more than one race group.

Immigration

Hawaii is considered a gateway to the U.S. for immigrants from Asia and the Pacific and has a sizeable immigrant

community. As of 2019, there were 273,012 immigrants in Hawaii, or nearly one-in-five (19.3%) of all residents. This is the 6th highest of all states. The ACS reports 58.9% of Hawaii's immigrants are women and 5.9% are children (under 18 years old). The top countries of origin are:

- Philippines (46%),
- China (8%),
- Japan (7%), and
- Marshall Islands (4%).

Most immigrants in Hawaii report speaking English well or very well (78%) and 28% have a college degree. Immigrants comprise an estimated 23% of Hawaii's labor force in 2018 and 26% of immigrants reported they were self-employed or owned their own businesses.

Undocumented Immigrant Estimates

According to the 2018 5-year ACS, there are an estimated 41,000 undocumented immigrants in Hawaii (3.3% of the population). The majority are from the Philippines. Hawaii is the only state where undocumented women (55%) outnumber men. The following table summarizes characteristics of Hawaii's undocumented immigrant population compared to the U.S.

Unauthorized Immigrant (UI) Characteristics	Hawaii	US
Unauthorized population	41,000 (3.3% of population)	10.7 million (3.3% of population)
Proportion of all immigrants that are undocumented	16.4%	24.0%
Proportion of adults that have been in the US for 5 years or less	34%	18%
K-12 students with unauthorized immigrant parent(s)	7.0%	7.6%
Proportion of labor force that is unauthorized	4.5%	4.8%
Industries and occupations with most unauthorized immigrant workers	Leisure/hospitality, service; Agriculture/farming	Construction, Service, Farming

DACA (Deferred Action for Childhood Arrivals)

As of 2019, 340 active DACA recipients live in Hawaii, with 1,201 people granted DACA status since 2012.^[1] An estimated 11% of those eligible in Hawaii applied for DACA.

Compact of Free Association (COFA)

COFA migrants includes those from the Federated States of Micronesia, Republic of Marshall Islands, and Republic of Palau. Under the compact, COFA migrants are designated as legally residing noncitizen nationals who can freely live, work, and study in the U.S. indefinitely. This status was negotiated in exchange for the U.S. military to control strategic areas in the region. The passage of the 1996 Welfare Reform Act removed COFA eligibility to key entitlement programs (Medicaid, Social Security, disability, and housing programs) with the state assuming most of the costs for services.

There are reports of high rates of morbidity due to chronic disease, reports of communicable diseases (tuberculosis, Hansen's disease/leprosy), and other medical concerns (i.e., cancer) that may be related to U.S. nuclear tests conducted in the Pacific nations. Challenges also exist due to language and cultural barriers within the population. In 2018, there were approximately 16,680 COFA migrants in Hawaii. Estimates indicate roughly 1,000 migrants are homeless. Migrants account for about 2-3% (400-600) births annually in Hawaii with low rates of prenatal

care utilization, high rates of low birth weight, and recent concerns about high rates of NICU admissions.^[2]

In 2019, the Title V agency served an estimated 4,371 COFA migrants at a cost of \$2.7 million. Programs reporting COFA clients served included WIC; state-funded Primary Care program (for uninsured/underinsured); Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program; Family Planning; Perinatal Support Services; and Early Intervention Services.

Languages Spoken

Because of Hawaii's ethnic diversity, limited English proficiency may impact access to healthcare for immigrant communities. An estimated 27.8% of Hawaii residents ages 5 years and over spoke a language other than English at home compared to 22.0% nationally. An estimated 11.9% of Hawaii residents reported limited English proficiency (4th highest state ranking) compared to 8.2% nationally. The most common languages spoken at home other than English include Other Pacific Island languages, Tagalog, Japanese, and Spanish, followed by Chinese, Korean, and Vietnamese.^[3]

In School Year 2018-19, 9.8% (16,579) of the state's public school students were enrolled in English Language Learner Program.^[1] The top five languages spoken by Hawaii public school students are Ilokano, Chuukese, Marshallese, Tagalog, and Spanish.^[4]

The state's unique characteristics, particularly the diversity in ethnicity, language, cultural practices, and significant immigrant population, underscores the need for disaggregated data. Disaggregating data can inform and expand understanding of the outcomes and experiences of subsets of the population and help evaluate whether programs are effective at meeting the needs of these groups. It can also help develop policy and programs that are appropriate and culturally/linguistically accessible. Further, differences in culture, language, age, and other demographic variables are important considerations when implementing Evidenced-Based Interventions (EBI). Adaptations to culturally tailor EBI may be needed especially when the evidence for the program was established with populations different from those in Hawaii.

Military

Other subpopulations within the state include U.S. Armed Forces personnel and their family members, which, in 2019, comprise an estimated 7.5% of the state's population (105,937 people).^[5] There are several major military health facilities to serve this population located on Oahu. The Tripler Army Medical Center is the only federal tertiary care hospital in the Pacific Basin. It supports 264,000 local active duty and retired military personnel, their families, and veteran beneficiaries. Medical services are also available on military bases through several clinics for active-duty members and their family members.

Homelessness

Hawaii's 2020 Point-in-Time homeless study estimates the total number of homeless individuals statewide at 6,458. The proportion of unsheltered individuals (56.5%) was higher than sheltered individuals (43.4%). After peaking in 2016, homeless rates dropped and have remained constant since 2018. About 31.6% (2,040) of the homeless were part of families, including 17.0% (1,101) children under the age 18 years.^[6]

Maternal and Child Population

The 2019 estimates show that there were 262,848 women of reproductive age (15-44 years old) a 2.1% decline from 2015, representing 18.5% of the entire state population.

Preliminary data suggests that the number of births continued to decrease between 2019 and 2020. There was a

steady increase in the number of births since the late 1990s with about 18,000 births every year in the state over the past 5 years.

The 2019 population estimates show that there were 169,801 children 9 years of age or younger in Hawaii, which represents a 0.4% increase from 2010. This group represents 12.0% of the state population. There were 160,303 children 10-19 years of age in Hawaii, which represents a 5.2% decrease from 2010. This group represents 11.3% of the state population.

Based on the 2019 National Survey of Children with Special Health Care Needs (CSHCN), there are an estimated 44,195 CSHCN, representing 14.7% of all children ages 0-17 years old.

Older Population

Hawaii's population, like the U.S., is aging. Based on 2019 population estimates, persons age 65 years and over comprised 27.2% of the population, compared to 14.3% in 2010. Nationwide, this population comprised 16.4% in 2019 compared to 13.0% in 2010. There are more older people in proportion to younger ones.

ECONOMY

Hawaii's economy is largely driven by tourism, real estate, construction sectors, and military spending. Like the rest of the U.S., the Hawaii economy has improved since the 2009 recession.

Economic Growth

Hawaii's economy has been greatly impacted by the COVID-19 pandemic. The Hawaii State Department of Business, Economic Development and Tourism (DBEDT) first quarter 2021 outlook report^[7] suggested that Hawaii's major economic indicators were mainly negative in the fourth quarter of 2020. Visitor arrivals, wage and salary jobs, state general fund tax revenues, and private building authorizations all decreased in the quarter compared to the fourth quarter of 2019.

During the April-December 2020 period, the average unemployment rate (not seasonally adjusted) was 15.1 percent. Hawaii lost 110,600 non-agriculture payroll jobs during as compared with the same period a year ago. All industry sectors lost jobs except for federal government jobs. The accommodation and food services and drinking places accounted for 52.6 percent of the total job loss at 58,200. Overall, statewide non-agriculture payroll jobs decreased by 16.9 percent in the April-December 2020 period. Visitor arrivals to the State during the fourth quarter of 2020 totaled 496,186, a decrease of 80.2 percent from the same quarter in 2019. However, due to the longer average length of stay, the average daily visitor census decreased only 70.7 percent in the fourth quarter of 2020.

At the national level, the U.S. economic growth rate was at 0.3 percent during the first quarter; fell to negative 9.0 percent in the second quarter; improved to negative 2.8 percent in the third quarter; and improved further to negative 2.5 percent in the fourth quarter as compared to the same quarter in 2019. The per capita real GDP in Hawaii was \$57,015 in 2019, \$525 or 0.9% higher than the U.S. average.^[8] Hawaii ranked 18th among the 50 states.

Unemployment

Hawaii unemployment rates reflect the state's economic recovery. The state's unemployment rate peaked at 7.4% after the 2009 recession with a record 47,000 individuals unemployed. Hawaii's unemployment rate soared during the COVID-19 pandemic with the annual average unemployment rate in Hawaii at 11.6% in 2020, 3.6% points higher than the U.S. average of 8.1%.^[9] Hawaii ranked from the 5th lowest among the 50 states in 2019 to the 2nd highest in 2020 due to the pandemic. Through 2021, Hawaii's unemployment rate decreased to 7.3% as the economy rebounded with a sudden return of the tourism market.

State Budget

The State Council on Revenues increased its forecast for growth in state tax revenues for FY 2021 (July 2020-June 2021) from -6.5% to -2.5%.^[10] For FY 2022, the council lowered its forecast for to 4.0% from 6.0%. The council forecasted that tax revenue growth will fall to 4.0% from 6.0% in FY 2023, remain at 4.0% in FY 2024, and decrease to 3.5% from 4.0% for FYs 2025-2027

The council acknowledged the COVID-19 virus continues to represent a serious risk to public health and the state's economy. Future tax revenues are highly dependent on the trajectory of the virus, new variants, availability and efficacy of vaccines, rapid low-cost testing and the state, county, and federal governments' ability to manage health risks while at the same time supporting economic activities. Given the prominent role of tourism in Hawaii's economy, the number of visitors to the state will have major impacts on the economy and tax collections.

Tourism

Due to the COVID-19 pandemic, total visitor arrivals by air in 2020 decreased by 7,556,762 or 73.8 percent, and average daily census decreased 167,699 or 68.2 percent.^[11] In the fourth quarter of 2020, the length of stay per visitor increased. Due to the longer length of stay, the average total daily visitor census decreased less than the decrease in visitor arrivals in the quarter. The total average daily visitor census was down 70.7 percent or 169,083 visitors per day in the fourth quarter of 2020 over the same quarter of 2019. Hawaii experienced a sudden surge in visitor numbers in the second quarter of 2021. The total average daily census was up 189,965 or 2,062.7 percent in the quarter, nearing pre-pandemic numbers because of vaccinations and the pent-up domestic travel demand. Foreign travel restrictions remain in place.

Poverty

Based on 2019 estimates, Hawaii's poverty rate was 9.3% (all ages in poverty), lower than the U.S. rate of 12.3%. This represents an estimated 128,722 individuals living in poverty in the state; over 36,461 or 12.4% of those under 18 years of age live in households below the Federal Poverty Level (FPL). Like unemployment rates, poverty rates are variable across counties: Honolulu 8.1%; Maui 11.9%; Kauai 8.6%; and Hawaii 13.2%. These numbers do not reflect impacts of the pandemic on Hawaii's individuals and households.

The official FPL obscures the struggles faced by many families in Hawaii because of the high cost of living and the generally low wage structure given the dependence of service industry jobs in tourism. The Census Supplemental Poverty Measure, which considers factors such as the cost of living and entitlements, reports that the 2019 poverty rate for Hawaii was 11.7%, 1.3 percentage points higher than the official poverty rate of 10.5%.^[12]

Wages

The average annual wage for employees in Hawaii was \$52,686 in 2019, \$6,523 or 11.0% lower than the U.S. average of \$59,209. Hawaii ranked 24th among the 50 states. Among private sector employees only, the situation is worse. Average annual wages for employees in the private sector was \$50,062 in 2019, \$9,140 or 15.4% lower than the U.S. average, ranking Hawaii 32nd.

ALICE Report

Hawaii's United Way Agency tracks working residents who live just above poverty and unable to afford basic necessities through a survey titled Asset Limited, Income Constrained, Employed (ALICE).^[13] In 2018, there were an estimated 33% of ALICE households in Hawaii that struggled to meet expenses for housing, childcare, food, transportation, and healthcare. These are in addition to the 11% of households below the Federal Poverty Level. The reason for the high percentage of ALICE households is:

- Low-wage jobs dominate the economy, and
- Cost of living outpaces wages.

Nearly 62% of all jobs in Hawaii pay less than \$20 per hour, with more than two-thirds of those paying less than \$15 per hour. These jobs were projected to grow far faster than higher paying jobs over the next decade. The ALICE report calculated the average annual household survival budget for a family of four is \$72,336, more than double the U.S. family poverty level of \$27,890. It is difficult for ALICE households in Hawaii to find affordable housing, job opportunities, and community resources. Public and private assistance helps but does not provide financial stability. When ALICE households cannot make ends meet, they are forced to make difficult choices such as forgoing healthcare, childcare, healthy food, or car insurance. These “savings” threaten their health, safety, and future – and they reduce productivity and raise insurance premiums and taxes for all residents.

HIGH COST OF LIVING

Hawaii has the highest cost of living in the nation – nearly 65% higher than the national average. In a recent report by Forbes.com, “The Best and Worst States to Make a Living,” Hawaii ranked as the worst state to make a living. The cost of living is 67% higher than what the average American makes. It also has the second-highest state income tax. The high cost of living may explain why the state experienced a slight population decline over the past three years (despite greater births than deaths).

Housing Costs

The primary driver for the high cost of living is Hawaii’s housing costs, which are the highest in the U.S. Hawaii’s high housing costs create a burden for families, resulting in less income available for other critical household expenses. Some families are forced to live in overcrowded, substandard housing or are forced into homelessness.

In March 2021, the median housing cost for a single-family dwelling on Oahu was \$950,000 and for a condominium was \$451,000. The median monthly owner mortgage cost in 2019 was \$2,472, \$863 or 53.6% higher than the U.S. average. Among these homeowners, 31.1% spent *35% or more of their household income*, which was higher than the U.S. average of 19.9%. Hawaii ranked the highest in the nation for this indicator. Not surprisingly, the homeownership rate in Hawaii in 2019 was one of the lowest in the U.S. (47th among the 50 states) at 60.2%, which was lower than the U.S. average of 64.1%.

Rental Costs

For working families, the high cost of fair market rent is out of reach. In 2019 an estimated 39.8% of occupied housing units in Hawaii were renter-occupied housing units (compared to 35.8% nationally). The median monthly gross rent for the renter-occupied units (excluding units not paying rent) was \$1,651, \$554 or 50.5% higher than the U.S. average of \$1,097. Hawaii has the highest cost among the 50 states.

Multigenerational Households

For some groups, cultural preference and tradition have led to multi-generational households; for others, it is a consequence of high housing costs. Based on 2019 ACS estimates, the percentage of multigenerational family households among all family households in Hawaii was 10.7%, which was higher than the U.S. average of 5.9%. Hawaii has the highest rate among the 50 states and also some of the largest household sizes especially among Samoan, Marshallese, and Tongan families. These conditions complicate COVID-19 social distancing efforts and have contributed to disparities in infection rates for these groups.

Cost of Health Insurance

Health insurance premiums continue to increase annually and can comprise a significant amount of an individual or

family's budget. According to the Hawaii State Insurance Commissioner,^[14] the average increase for health insurance group plan premium rate significantly declined from 2011 to 2014 to a 4% average annual increase compared to 9.3% average annual increase between 2007 and 2010. The impact of the Affordable Care Act (ACA) on individuals and family budgets/expenses has yet to be determined.

Health Services Infrastructure

There are about 100 health facilities in the state.^[15] Of the state's 29 hospitals, 12 are labor and delivery hospitals. There are three pediatric hospitals with Neonatal Intensive Care Units on Oahu while other hospitals have less acute pediatric services. Hawaii has 15 federally qualified health centers, 11 rural health clinics, and seven Native Hawaiian health systems sites. Maps of these facilities are in the Supporting Documents section.

There are 330 family and general practitioners, 200 obstetricians and gynecologists, and 180 pediatricians in the state.^[16] Based on the 2019 population estimate (1,415,872), there are 14.1 per 100,000 population obstetricians and gynecologists, which is significantly higher than the national rate (5.7 per 100,000 population). There are 12.7 pediatricians per 100,000 population, which is like the national estimate (9.1). The rate for family/general practitioners (23.3 per 100,000 population) is similar to the national rate (33.3). Despite Hawaii's high ratio of providers to population, many of the state's medical and specialty providers are located on Oahu and many of the state's rural areas are designated as shortage of medically underserved.

Healthcare Shortage Designations

Shortage Designations are a representation of an area's or population's need based on several factors, including health professional presence, socio-economic and demographic data, language barriers, health indicators, population's access to health care, and travel time to nearest available provider. Maps of Hawaii's shortage areas are included in the Supporting Documents.

Health Professional Shortage Areas

A Health Professional Shortage Area (HPSA) is a geographic area, population, or facility with a shortage of primary care, dental, or mental health providers. Hawaii's primary care HPSA cover nearly all major islands and include Kauai, Maui, Molokai, Lanai, Hawaii Island, and the rural northern half of Oahu. Hawaii's mental health HPSA include the six major islands of Kauai, Maui, Molokai, Lanai, Hawaii Island, and Oahu. Hawaii's dental health HPSA include Maui, Molokai, Lanai, Hawaii Island, and the Kalihi-Palama district of Oahu due to its low-income population.

Medically Underserved Areas

A Medically Underserved Area (MUA) is a geographic location that has insufficient health resources (manpower/facilities/services) to meet the medical needs of the resident population. Hawaii's MUA include Kauai, Molokai, Hawaii Island, and the East area of Maui, which includes Hana.

Medically Underserved Population

A Medically Underserved Population (MUP) is the population of an urban or rural area designated as an area with a shortage of health resources (manpower, facilities, services) or a population group having a shortage of such services. Hawaii's MUP include Lanai, West Maui, and a part of Oahu that includes the community of Wahiawa.

HEALTH INSURANCE & HEALTHCARE REFORM

Hawaii has a long history of supporting initiatives to make health insurance broadly available to residents. Hawaii was among the first six states that implemented a Medicaid program in 1966. In 1974, Hawaii implemented its Prepaid Healthcare Act (PHCA), which mandated that most employers make health insurance available to employees who work at least 20 hours a week.

In conjunction with the Affordable Care Act (ACA), Hawaii adopted Medicaid expansion and transitioned to the federally run exchange in 2017. Hawaii is one of the few states where enrollment in Health Plans through the exchange increased every year. Under the ACA Medicaid expansion, coverage increased to 138% of FPL. The number of people on the program rose significantly from 292,000 in 2013 to about 345,709 in 2018.^[17] This mirrors the national average of roughly 25% Medicaid coverage of the state population. In Hawaii, Medicaid covers more than 40% of the state's children. Under ACA more than 20,000 people enrolled in private insurance and about 50,000 people enrolled in Medicaid. Through its efforts, Hawaii consistently reports low uninsured rates and high overall health scores, although stark disparities remain.

In 2018, state lawmakers integrated some of the significant pieces of the ACA into the Prepaid Healthcare Act to ensure the following benefits remained available under Hawaii law:

- Ensuring dependent coverage for adult children until the age of 26 years;
- Prohibiting health insurance entities from imposing a preexisting condition exclusion; and
- Prohibiting health insurance entities from using an individual's gender to determine premiums or contributions.

MEDICAID

The Department of Human Services (DHS) Med-QUEST Division (MQD). QUEST administers the State Medicaid program. The QUEST program is designed to provide Quality care, Universal access, Efficient utilization, Stabilizing costs, and to Transform the way healthcare is provided to recipients. QUEST objectives are: to expand medical coverage to populations previously ineligible for Medicaid and to contain costs by shifting fee-for-service to a managed care delivery system. Savings realized from such a shift would be used to expand coverage. Under this waiver all Medicaid eligibles, excluding those with disabilities and over 65, received their services through managed care.

Hawaii's Medicaid eligibility levels for children are much higher than the national average and about average for pregnant women and parents.

- Children ages 0-18 qualify with family income levels up to 300% of the federal poverty level (FPL)
- Pregnant women qualify with family income up to 191% of FPL
- Parents and other adults qualify with family income up to 133% of FPL

Hawaii Medicaid enrollments increased by 28% for the duration of the pandemic with over 92,000 new enrollees since March 2020 to March 2021. As of March 2021, the Medicaid Program provided coverage to record number of 419,228 individuals with 156,580 of them being children through traditional, CHIP, and current and former fostercare eligibility rules.^[18] Additionally, the program continues to support medically needy children who are determined to need nursing home level of care.

Hawaii's SCHIP program, a Medicaid expansion, covers all children under 19 years of age with family incomes up to 300% of the FPL for Hawaii. There is no waiting period for SCHIP eligibility. All immigrant children who are Legal Permanent Residents or citizens of a COFA nation are enrolled in a Medicaid program under SCHIP.

Medicaid beneficiaries have a choice to select medical plans from five participating health plans: AlohaCare, HMSA, Kaiser Foundation Health Plan, 'Ohana Health Plan, and United Healthcare Community Plan. All the health plans provide services to beneficiaries statewide, except for Kaiser Foundation Health Plan, which operates only on the islands of Oahu and Maui.

GOVERNMENT

Hawaii's Executive Branch of government is organized into 16 cabinet-level agencies. The major health programs are administered by the Department of Health (DOH) and by the DHS. DHS administers the Medicaid program while DOH serves as the public health agency for the state. In addition to Medicaid, DHS houses the major social service/entitlement programs (Child Welfare, Temporary Assistance for Needy Families, Supplemental Nutrition Assistance Program, and Vocational Rehabilitation).

DOH is the only public health agency for the state. There are no local health departments in Hawaii. The state's three neighbor island counties (Hawaii, Maui, and Kauai) are represented by District Health Offices that oversee DOH-staffed services at the county level. Contracted services on the neighbor islands are handled directly by the central Title V programs on Oahu.

The governor appoints all state department directors; the director of health reports directly to the governor. DOH is divided into three major administrations: Health Resources Administration (HRA), Behavioral Health (BHA), and Environmental Health (EHA). There are six major divisions within HRA including the Family Health Services Division (FHSD), which is responsible for the administration of all Title V funding. The three branches within FHSD are Maternal and Child Health; Women, Infants, and, Children (WIC) Services; and Children with Special Health Needs.

Democratic Governor David Ige was re-elected to a second term in 2018. During the pandemic, a new Director of Health was appointed, Elizabeth Char, M.D. The former FHSD Chief, Danette Wong Tomiyasu, MBA, is the Deputy Director for HRA. Matthew J. Shim, Ph.D., MPH, is the current FHSD Chief/Title V Director.

STATUTORY AUTHORITY

The Title V agency, Family Health Services Division (FHSD) falls within the purview of Title 19 Chapter 321 of the Hawaii Revised Statutes. For listing of statutes pertaining to the division and programs see Supporting Documents.

COVID-19 Impact and Response

The COVID-19 pandemic has had far ranging impacts across Hawaii's health, economic, education, and employment sectors. The complexities of protecting public health and improving the state's economy remain challenging.

Early in the pandemic, Gov. Ige acted to protect Hawaii residents from mortality and morbidity associated with the pandemic. The first proclamation declaring a state of emergency was enacted on March 4, 2020, preceding the federal government's response to the pandemic on March 13, 2020. The governor's response directed the state and counties to implement a mandatory stay-at-home order; self-quarantine for all persons entering the state and traveling between counties; limited non-essential business, restaurants and bars, and gatherings; and mandated safe practices including mask wearing and physical distancing to reduce the spread of COVID-19. The state also implemented active COVID-19 testing and contact tracing and, once available, implemented vaccinations to mitigate disease impacts.

COVID-19 cases and deaths, as a result of these actions, were minimized. The state reported a cumulative 36,250 confirmed COVID-19 cases statewide and 508 deaths as of June 26, 2021. Hawaii's cumulative death rate of 38/100,000 has been the lowest in the country. Disparities were seen with Native Hawaiian, Filipino, and Pacific Islanders experiencing higher rates of infection and death. The Delta variant was first detected in Hawaii in June 2021. Hawaii, like most of the U.S., is now experiencing a surge in cases, resulting in reinstated emergency restrictions.

Hawaii's vaccination program began with healthcare providers in December 2020, opened to all adults on April 19,

2021, and all persons 12 and older on May 12, 2021. Among the state's population, 62.9% are fully vaccinated. There are differences by county: 64% Oahu, 56% Maui, 59% Hawaii, and 62% for Kauai.

The spread of COVID-19 dramatically impacted Hawaii's families and businesses. The pandemic impacted the mental and physical health of residents but also impacted employment. The state's preliminary unemployment rate rose sharply from 2.4% in March 2020 – one of the best in the nation – to 23.8% in April 2020. As businesses have reopened on a measured basis, the unemployment rate decreased to 14.3% in October 2020 and is currently at 8.0%. With so many unemployed, the State Unemployment Insurance (UI) Trust Fund was quickly depleted, and the State had to obtain a \$1.0 billion loan for calendar year 2020 from the federal government to pay UI claims, for which the State will pay the interest.

In addition to an increase in unemployment applications, the state reported:

- 29% increase in Medicaid enrollment (1/19 – 7/21) and 94,795 enrollments as of 3/6/2020
- 52,235 recipient increase to the Supplemental Nutrition Assistance Program (SNAP) between 3/2020 and 6/2021
- 36.4% of residents concerned about paying usual household expenses

The Department of Health has worked tirelessly to protect and inform the public about prevention, treatment, and resources for those experiencing hardship. Materials, PSAs, and media releases included translations in languages of vulnerable communities and culturally tailored messaging. The state worked with an array of public, private, and community partners to support pandemic mitigation efforts and protect public health.

The state received and benefited from federal funds intended to support urgent COVID-19 response efforts to bring the pandemic under control, replace lost revenue, strengthen support for vital public services, provide assistance to individuals and households, and help retain jobs. The sources of federal funds are:

- Families First Coronavirus Relief Act
- Coronavirus Aid, Relief and Economic Security Act (CARES)
- American Rescue Plan Act (ARPA)

While no one can predict how long this worldwide health crisis will last, there is hope that continued mitigation efforts and increasing vaccination coverage will help the state recover from the pandemic.

[1] American Immigration Council. (2020). https://www.americanimmigrationcouncil.org/sites/default/files/research/immigrants_in_hawaii.pdf

[2] COFA reports (2018) <https://www.doi.gov/oia/reports/Compact-Impact-Reports>.

[3] Hawaii State Department of Education, English Language Learners, P. 48 of the Consolidated State Performance Report for school year 2015-16 <https://www2.ed.gov/admins/lead/account/consolidated/sy15-16part1/index.html>

[4] Hawaii State Department of Education, Who are Hawai'i's English Language Learners (ELS)? School year 2018-19. <https://www.hawaiipublicschools.org/DOE%20Forms/EL%20Infographic.pdf>

[5] Number of armed forces residents and military dependents at http://dbedt.hawaii.gov/economic/databook/2019-individual/_01/

[6] <https://homelessness.hawaii.gov/point-in-time-count/>

[7] Report on Hawaii's economy <http://dbedt.hawaii.gov/economic/qser/>

[8] <http://dbedt.hawaii.gov/economic/ranks/>

[9] 2020 unemployment rate is found at <https://www.bls.gov/lau/lastrk20.htm>

[10] General fund forecast on March 13, 2020, http://tax.hawaii.gov/useful/a9_1cor/

[11] <http://dbedt.hawaii.gov/economic/qser/tourism/>

[12] Supplemental Poverty Measure is found on <https://www.census.gov/library/publications/2020/demo/p60-272.html>

[13] <https://www.auw.org/alice-study-financial-hardship-hawaii>

[14] Department of Commerce and Consumer Affairs news release <http://cca.hawaii.gov/ins/news-release-insurance-commissioner-reduces-hmsas-rate-increase-request/>

[15] Based on the facility address provided on <https://health.hawaii.gov/shpda/agency-resources-and-publications/health-care-utilization-reports-and-survey-instructions/2019-data/>

[16] Based on 2019 state data provided in Form 11.

[17] Based on Department of Human Services, State of Hawaii, 2018 Annual Report found on <http://humanservices.hawaii.gov/reports/annual-reports/>

[18] Based on the 2019 enrollment report from <https://medquest.hawaii.gov/en/resources/reports.html>

III.C. Needs Assessment

FY 2022 Application/FY 2020 Annual Report Update

C.1 Needs Assessment Update Background and Context

COVID-19

The impact of the COVID-19 pandemic is unprecedented in this generation and has had far ranging impacts across the health, economic, education, and employment sectors.

The state reported a cumulative 36,250 confirmed COVID-19 cases statewide and 508 deaths as of June 26, 2021. Hawaii's cumulative death rate of 38/100,000 has been the lowest in the country. Disparities were seen with Native Hawaiian (NH), Filipino, and Pacific Islanders experiencing lower vaccination rates, higher rates of infection, and death. The Delta variant was first detected in Hawaii in June 2021.

The pandemic resulted in a 98.8% decrease in travelers to the state in April 2020. Hawaii's unemployment rate was among the highest in the country at 22% in April 2020; it has improved but still remains high at 8.0%. Early January 2021 data from the Household Pulse Survey found that 54.6% of adults anticipated eviction or foreclosure in the next two months and that 36.4% of respondents found it difficult to pay usual household expenses.

Those in the service sector were more likely to experience unemployment. Food banks in the state reported serving 60% more people than prior to the pandemic. Further, schools transitioned to distance learning, presenting childcare and educational challenges. Those without broadband internet access (BIA) were left with limited or no access to educational, health, or social resources underscoring its role as a social determinant of health. The economy has made steady improvements since its low in April 2020 but remains at about 75% of its pre-pandemic status.

The Department of Health (DOH) has worked tirelessly to protect and inform the public about prevention and treatment of COVID-19 and to share resources for those experiencing hardship. Materials, PSAs, and media releases included translations in languages of vulnerable communities and culturally tailored messaging. FHSD staff also participated in testing and vaccine clinics, and contact tracing. Public health workers are feeling the strain as the pandemic continues with little relief in sight (CDC, MMWR).

The Needs Assessment (NA) update

The NA builds upon the process and findings of last year's Five-Year Needs Assessment. A mixed methods approach was used for data collection and evaluation purposes. The NA utilized the same guiding principles that served as the foundation for the Five-Year NA: promote health equity; consider social determinants of health; utilize a life course approach; value the roles of our partners and communities; utilize evidence-based/informed practices; and focus on primary prevention and early intervention.

The ongoing NA examined a variety of primary and secondary data sources, surveyed FHSD staff on the impact of the COVID-19 pandemic on program operations, and engaged external stakeholders in discussion of emerging needs and priorities. The findings support and inform Hawaii's Title V strategic planning, decision-making, and resources allocation.

The following data resources were utilized for ongoing needs assessment activities:

FAD continued to provide reliable information for ongoing needs assessment. FHSD data staff provided interpretation of trends and subgroup analyses to identify disparity by key variables such as race/ethnicity, age, education, and income. However, limitations such as small sample sizes required aggregated multiple year estimates for some indicators and group comparisons. When samples size permitted, efforts were made to disaggregate ethnicity data to better identify disparities and address program planning needs. Larger sample sizes are needed to support disaggregation of ethnicity data to match Hawaii's unique population.

Additionally, a survey on the impact of the COVID-19 pandemic was completed with FHSD program managers.

Data Sources
Hawaii Emergency Management Agency
Hawaii Department of Health, Disease Outbreak and Control Division
Hawaii PRAMS (Pregnancy Risk Assessment Monitoring System)
Hawaii Vital Statistics within DOH's Office of Health Status Monitoring (OHSM)
Hospital databases offer information around inpatient and emergency department visits
Behavioral Risk Factor Surveillance System (BRFSS)
Youth Risk Behavior Surveillance System (YRBSS)
Hawaii's Child Death Review (CDR), Maternal Mortality Review (MMR), and Domestic Violence Fatality Review (not all reviews active/reports available)
CDC's National Vital Statistics (NVSS)
National Center for Health Statistics (Natality Data)
United States Census Bureau, American Communities Survey (ACS)
US Bureau of Labor Statistics
CDC's Pulse Survey
Substance Abuse and Mental Health Services Administration (SAMSHA)
Title V Federally Available Data (FAD)
Hawaii Emergency Management Agency
Hawaii Department of Health, Disease Outbreak and Control Division

Title V programs normally work with partners to both gather and share data that is meaningful and relevant to the families served. Data are shared through infographics, factsheets, presentations, and publications. Feedback is gathered through client surveys, public, and stakeholder response to presentations, reports, and surveys. Data efforts have been limited by vacant epidemiology positions.

C.1.a. Ongoing Needs Assessment Activities

Many planned FY 2020 activities were delayed/postponed due to COVID-19. Several needs assessment related activities are in progress.

- Collaboration with the University of Hawaii (UH) Center for Disabilities Studies to identify and review existing data, as well as conduct primary data collection with CSHN families to assess COVID impacts and support transition to adult healthcare.
- Collaboration UH Office of Public Health Studies to conduct MCH workforce survey to collect demographic data (to assess workforce diversity), assess well-being, and emerging training needs/supports given the pandemic.
- All programs continue ongoing assessment activities regarding program performance and pandemic impacts.

C.1.b. Summary of Health Status Changes of the MCH Population

Four new state priorities were added in FY 2021 as a result of pandemic impacts and new federal funding opportunities. All four priorities address health equity and are supported by state and federal data.

- Food Insecurity through WIC services
- Telehealth expansion to underserved communities
- Pediatric Mental Health
- Child Wellness Visits/Immunizations

Women/Maternal Health - An estimated 246,369 women of reproductive age (WRA), aged 15-49 years, live in Hawaii, making up 43% of the female population in the state. The demographic characteristics of this group reflect those of the U.S., except the state's race groupings, which have a high proportion of Asians, Native Hawaiians, and Other Pacific Islanders (NHOPI). Twenty-one percent of WRA in Hawaii are White, followed by NH (23%) and Filipino (20%), with all other races being less than 15%, respectively. Most WRA are married (48%), heterosexual (93%), a high school (29%) or college graduate (30%), and employed (62%) with an annual household income of \$75,000 or more (33%).

Statewide trends of key health indicators suggest that WRA are engaged in the healthcare system, and their health status is relatively stable. Health insurance coverage is at 91%, with approximately 19% having state-sponsored insurance. There was improvement in the percentage of women who had a preventive medical visit (78%) in 2020, up from (77%) in 2019, exceeding the state objective of 77%.

Most WRA use conception for family planning. In 2019, 59% of WRA used one or more contraceptive methods during their most recent sexual encounter; however, it was the lowest percentage among all U.S. women (Guttmacher Institute, 2017). Most WRA in Hawaii are waiting longer to get pregnant, with birth and fertility rates dropping among women in their 20s and rising among women in their 30s and 40s.

High percentages of WRA report having good physical and mental health at nearly 90% and 70%, respectively. Almost 20% have two or more chronic conditions; 16% have at least one physical or mental disability. About 49% are current drinkers; 18% are binge drinkers. Fifteen percent of WRA are current cigarette smokers, and 5% are current e-cigarette (vape) users. Rising trends in obesity and risky health behaviors, particularly in younger women, underscore the focus on preventive healthcare and expanded telehealth for rural communities.

Perinatal and Infant Health - In 2020, there were 15,780 births to Hawaii residents. In 2019, the birth rate was 11.9 per 1,000 for women aged 15–44 years (similar to the national rate of 11.6) and was highest among those aged 30–34 years (98.3) and 25–29 years (93.7) (NCHS). Among teen mothers aged 15–19 years, the birth rate is 15.2 per 1,000, similar to the U.S. rate of 17.4, and is highest among NHOPIs.

PRAMS 2012–2015 aggregated data indicates most live births occurred to women who were Asian (31%), NH or part-Hawaiian (28%), White (24%), and Filipino (17%). Over half (56%) of women had an annual household income at or above 185% of the federal poverty level. Most women were married (69%), had private health insurance coverage (52%), and had one or more previous births (66%). At pregnancy, 27% of women had public health insurance and 42% were WIC participants. The 2019 rate of prenatal care in the first trimester of pregnancy was unchanged from 2018 data (72%) but a significant decrease from 2015 (77%). Pregnant women less than 20 years of age, uninsured or on Medicaid, with a high school education or less, and NHOPI were less likely to start early prenatal care.

In 2017, severe maternal morbidity was 84.7 per 10,000 hospitalizations, which was not significantly different from the U.S. rate of 70.9 (FAD). The rate of severe maternal morbidity reported in 2018 was 104.3 per 100,000 live births – significantly higher than the national estimate and an indicator to monitor and address.

The preterm birth rate was 10.6 (NVSS, 2019); NH, Filipino, Samoan, Black, OPI, and Others had significantly higher rates of preterm birth when compared to White. Infant mortality has increased from 5.3 deaths per 1,000 live births in 2011 to 6.8 in 2018. The upward trend is concerning and exceeds the Healthy People 2020 objective (6.0). Infant mortality was significantly higher for NH and Black infants as compared to White infants. Low birth weight (LBW) deliveries were statistically higher for these groups as well (2018–2020 HDOD-OHSM).

In 2016, 89% of infants were ever breastfed. A lesser proportion of mothers continue to breastfeed exclusively through six months at 33%, higher than the U.S. estimate (25%). PRAMS data from 2016 showed that 78% of infants are placed on their backs to sleep, but only 20% are placed on an approved sleep surface and 32% are placed to sleep without soft objects or loose bedding. Disparities were noted for mothers who were 20 years or younger, at or below the 185% of the federal poverty level, and Native Hawaiian.

Adolescent Health - There are an estimated 161,000 adolescents in Hawaii; of those, 83,000 aged 10–14 years and 78,000 aged 15–19 years (Census). The racial and ethnic profile of adolescents suggests that most are of two or more races, NHOPI, or Asian.

Trends of several health indicators suggest that adolescents in Hawaii are as healthy as most U.S. adolescents. There are disparities that lead to worse outcomes for subgroups. 2016–2018 data indicates 75% of adolescents, ages 12–17 years, had a preventative medical visit within the past year, which met the 2019 state objective. Adolescents with college-educated parents were more likely to have a preventative visit compared to those whose parents had completed some college or below; similar differences exist for low-income individuals and non-English language speakers.

The leading causes of adolescent mortality in Hawaii are unintentional injuries (e.g., motor vehicle injuries, suicide). In 2018, the overall mortality rate for adolescents aged 10–19 years was 25.1/100,000; not significantly different from the U.S. estimate (32.2/100,000). Data from 2016 to 2018 showed that males had a noticeably higher mortality rate (36.4) than females (19.4); there were no significant differences across racial groups.

The percent of adolescents engaging in sexual activity remains stable; their practices of good sexual health seem to be improving. In 2019, 18% of high school students were currently sexually active, with 64% using some form of birth control (YRBS). A high percentage of adolescents are vaccinated against HPV, compared to the U.S. overall. Births among females ages 15-19 in the state reduced significantly from 33.0 per 1,000 in 2010 to 17.2 in 2018 and was similar to the U.S rate at 17.4. NHOPIs and those of multiple races had higher teen birth rates.

There is an observed shift in trends in tobacco use from smoking cigarettes to e-cigarettes (vaping). In 2019, 18% of high school students reported smoking cigarettes; however, almost double (48%) were vaping. Current e-cigarette use is significantly higher among Hawaii's adolescents than those nationwide (13%).

For suicide and depression, 35% of high school students report experiencing depression and 10% attempted suicide within the last 12 months. Disparities are:

- Native Hawaiian youth engage in risky behaviors that exceed state averages in every category (e.g., suicidal ideation, fighting, and carrying weapons, etc.)
- Other Pacific Islander youth have the highest rates of sexual abuse and forced intercourse by any person (not a partner)
- Filipino youth have high rates of depression
- Caucasian youth have high rates of substance abuse
- Japanese and Other Asian youth have among the highest rates of emotional and physical abuse by a partner in middle school

Child Health - There are approximately 300,000 children under 18 years old in the state, roughly 21% of the total population. Since 2012, there is a steady decline in the percentage of children under 18 years old. About 31% are classified as being of two or more races (31%), followed by Asian (24%), White (14%), NHOPI (11%), and all other races less than 5%. The economic well-being of Hawaii's children improved since 2010 with fewer children in poverty (12% in 2018 vs. 14% in 2010) and fewer children whose parents lack secure employment (26% in 2018 vs. 30% in 2010). A lower percentage of children in Hawaii (30%) live in single-parent households compared to all U.S. children (35%). This data does not reflect impacts of the COVID-19 pandemic on family's economic, housing, food security and stress.

Hawaii ranks 17th in overall child well-being among all U.S. states per Hawaii's Kids Count. Hawaii's child mortality rate decreased among those aged 1 through 9 years from 18.2 per 100,000 in 2018 to 13.3 in 2019. Hospitalizations for non-fatal injury for children aged 0–9 years declined to 77.4/100,000 in 2019 from 99.7/100,000 in the previous year. The rate is significantly below the national rate of 128.6/100,000.

Most of Hawaii's young children do not receive developmental screening needed to identify and diagnose unmet behavioral and learning milestones. Data from 2020 showed that 31.6% of children ages 9 through 35 months received a developmental screening in the past year. But most children do access preventive services, including immunizations; however, there are health inequities by age group and race. In 2020, 86% of children aged 1-17 years had a preventive dental visit within the past year; routine oral health care is markedly lower among children 1 and 5 years (72%) compared to older age groups.

Other indicators suggest children have challenges related to maintaining a healthy lifestyle. Among children aged 10–17 years, 12% were considered obese; though this is lower than the U.S. estimate (15%), it highlights a need for better nutrition

and more physical activity. Among children aged 6–11 years, less than a quarter (21%) were physically active for at least 60 minutes per day, which was lower than the national average (28%). Safety of the state's youngest children continues to be a community concern. The 2019 rate of confirmed child abuse and neglect cases per 1,000 children aged 0 to 5 years is 5.5.

Title V goals and indicators for children include increasing developmental screening, access to mental and behavioral health, reducing rates of child abuse, as well as increasing child wellness visits and immunization. The latest data indicates that 71% of children received recommended vaccines in 2018. Between 2016-2017 and 2018 rates of preventative visits for children remained constant with 85% and 85.6% of children receiving a yearly preventative dental visit. Disparities between younger and older children also continued. The number of children ages 9 through 35 months who received a developmental screening using a parent-completed screening tool in the past year decreased from 36.5 in 2019 to 31.6 in 2020, although the estimates should be used with caution given the small sample size for this indicator.

Children with Special Health Care Needs (CSHCN) - The population of CSHCN in Hawaii is estimated to be 47,369, representing 14% of the child population under 18 years of age and 3% of the larger state population. Hawaii's Title V program focuses on transition to adult healthcare for this domain. Data for 2016-2017 show that the estimate for Hawaii (22%) was similar to the national estimate (17%) in those with special healthcare needs. The estimates in those without special healthcare needs were the same in Hawaii and the nation (14%). There were no significant differences reported by subgroups.

According to data from the 2017–2018 National Survey of Children's Health (NSCH), 13% of children ages 0-17 years in Hawaii have special needs, compared to the national estimate of 18%. Almost half (49%) are classified as other race, followed by Asian (17%), White (12%), Black (1%), and 21% Hispanic/Latino. There is no significant difference in race and ethnicity between CSHN and children without special health needs. Among CSHN, there are more males (61%) than females—a trend that is also observed nationally. A high percentage of CSHN (98%) have health insurance with 66% using primarily private insurance for medical services and 27% using public insurance. Most CSHN live in two-parent households (66%), have at least one adult in the home with a college degree or higher (49%), and live in a home with an annual income at 200-399% of the federal poverty level (43%), suggesting some economic stability.

Receiving adequate medical care and being in home and school environments that are free of neglect and abuse are essential to each child's development. From 2017 to 2018, nearly half (45%) of CSHN ages 0-17 had a medical home, which was similar to the national estimate (43%) but lower than the Healthy People 2020 objective (52%). Among this group, a relatively small percentage (17%) are in a well-functioning system of care that integrates a family-centered home with comprehensive needs-specific medical attention; however, this percentage is similar to those nationwide (14%). During the same period, among children ages 3-17 with a mental or behavioral condition, 54% received treatment or counseling, suggesting that only about half of children acquire the psychological care they need.

Of concern is 2017-2018 data showing that only a quarter of adolescents with and without special healthcare needs, ages 12 -17 years, received services needed to make transitions to adult healthcare (24.7%).

FHSD COVID-19 Survey Findings

FHSD program staff completed a 23-item survey regarding the impacts of the pandemic on program operations. The survey findings indicated that program staff shifted to working from home, providing information and education on COVID-19 to individuals/families, providing virtual or telehealth services, and working with partners to modify contracts to support continued services to clients/families. Specifically:

- 96% of managers reported COVID-19 impacts on program operations
- 79% of FHSD programs shifted from in-person to telehealth, phone, and virtual operations
- 71% of programs reported making workspace changes and modifications to meet safety guidelines
- 75% of programs continue to operate under revised protocols

Despite the many challenges experienced as a result of the pandemic, nearly half of program managers reported that the pandemic had strengthened program operations and partnerships.

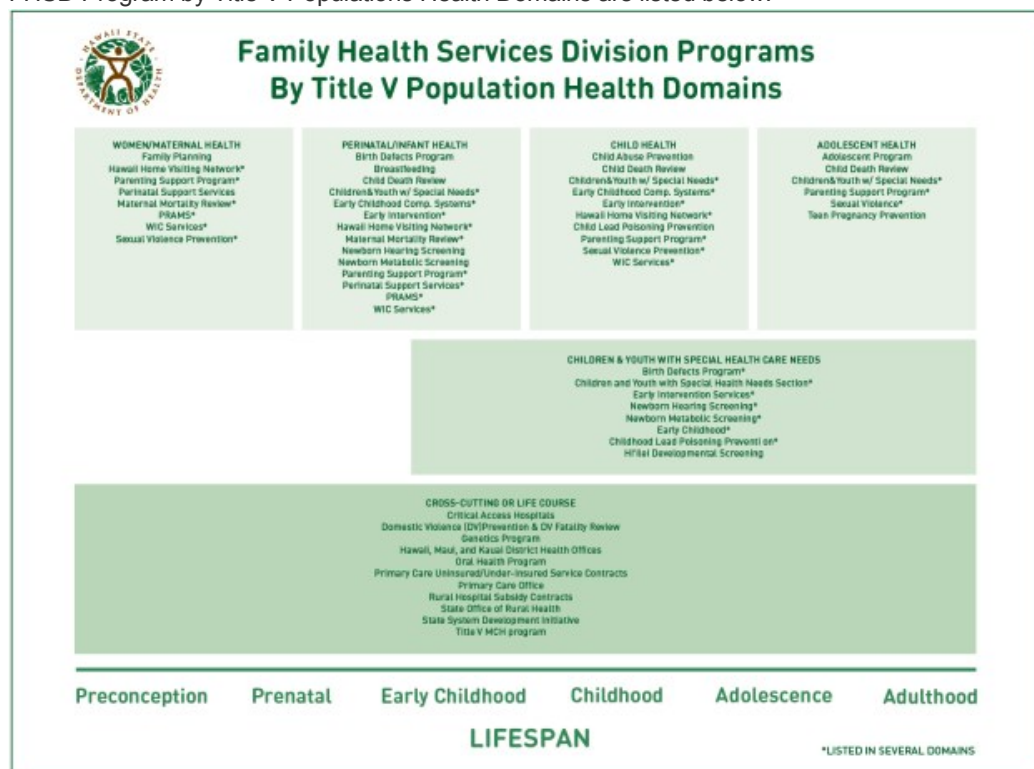
The full list of survey questions is available in the Support Documents section of this report. A final report is being prepared.

C.1.c. Title V Program Capacity Updates and Changes

Several new appointments were made to DOH leadership, which are reflected in the DOH Organizational Charts in Section IV of this report. In 2020, Elizabeth Char, M.D., was appointed DOH Director, and in 2021, two new DOH Deputies were appointed by the governor: Kathleen Ho for the Environmental Health Administration and Marian Tsuji for the Behavioral Health Administration.

Title V programs continue to provide all levels of services across its programs statewide. With the advent of COVID-19, direct service program staff were able to transition fairly easily to provide telehealth services, switch to telework, and continue cross-agency/community partnership via Zoom.

FHSD Program by Title V Populations Health Domains are listed below.



FHSD has 283 FTE staff, of which 20.85 FTE are Title V-funded, and 43 FTE are located on neighbor islands.

	Total FTE (all funding sources)	Title V FTE*	Hawaii FTE	Maui FTE	Kauai FTE
FHSD	30.0	4.5	2.0	3.0	2.0
MCH Branch	35.0	6.75	1.0	0	0
CSHN Branch	149.0	9.6	6.0	3.0	2.0
WIC Branch	69.0	0	13.0	7.0	4.0
TOTAL	283.0	20.85	22.0	13.0	8.0

*Includes vacant positions.

FHSD's administration, branches, and programs remained largely the same with the following changes:

- In FY 2020 FHSD hired a Title V-funded Information Specialist III to manage communications and media for the

Division.

- The FHSD Hawaii County Family Health Services Coordinator (Registered Nurse) responsible for FHSD services (Children with Special Health Needs, Early Intervention, Maternal and Child Health, WIC) was on medical leave for most of FY 2020.
- Maui District Health Office (DHO) oversight for the ECCS grant with the end of the grant in FY 2021.
- Title V Family Leader: Leolinda Iokepa was on medical leave for most of FY 2020. A replacement is currently being discussed. Parents continued to serve on advisory boards and in the case of WIC, as paid peer breastfeeding counselors. See Family Partnership section for other updates.

Title V COVID-19 Response. No Title V funds were used for direct COVID-19 disease prevention/control. However, four of FHSD's state-funded Registered Nurses (RN) were reassigned for direct work on COVID-19 disease prevention and control work. FHSD Maui and Kauai RN Supervisors were deployed for COVID-19 testing, contract tracing, and vaccinations that started in December. They continue to serve in this capacity. On Oahu, a CSHNB nurse assisted with contract tracing through overtime hours. Another CSHNB nurse was deployed two to four days/week through 2020 continuing to April 2021 with the Disease Investigation program to assist with infection investigation and control in long-term care facilities including:

- Conduct Infection Control Assessment/Response surveys with the skilled nursing facilities, assisted living facilities, large adult care homes, ambulatory surgery centers, and dialysis centers statewide.
- Initiate disease investigations in long-term care facilities.
- Provide infection control guidance to long-term care facilities.
- Develop and distribute protocols for adult day care and day health centers.

The FHSD Division Chief and Admin Officer served on the Department Operating Center (DOC), the incident command structure, which was activated for the COVID-19 public health emergency (PHE). For several months, the Title V Division Chief served as head of the Planning Section while the FHSD Administrative Officer served as the lead for Logistics.

For FHSD programs, COVID-19 work also included planning and prevention work with the state early childhood providers. Title V scheduled a webinar with the State Epidemiologist and early childhood/childcare providers to clarify the evolving risks and safety protocols for these service settings. Providers were able to submit specific questions for response. The Title V director also served as a critical liaison between early childhood providers and the DOH team developing the state COVID-19 vaccination plan to assess the sector's readiness and inclusion in the plan priority groups.

C.1.d. Title V Partnerships and Collaboration

The Title V program continues to work closely with a diverse set of agency and community partners across population domains. Formal and informal partnerships are in place with other programs within DOH (e.g., Chronic Disease Branch, Developmental Disabilities Division); other state and county organizations (e.g., Department of Education, Department of Human Services, Executive Office of Early Learning; over 25 healthcare organizations (e.g., Shriners' Hospital, Federally Qualified Health Care Centers, Aloha Care); over 35 community-based organizations (e.g., Coalition for a Drug-Free Hawaii, Perinatal Action Network, Youth Tobacco Prevention Coalition); and national partners (e.g., Centers for Disease Control and Prevention, Department of Agriculture). The full list of Title V partners is available in the supplemental documents sections of this report.

The four new state priorities focus on COVID-19 response initiatives with existing partners. More work was conducted in partnership with DOH Disease Outbreak and Communicable Disease (DOCD), Immunization Branch, Office of Public Health Preparedness, Child and Adolescent Mental Health, Planning Office, and Communications Office.

Among the partners above, the Department of Human Services (DHS) administers the major federal social service/entitlement programs including Medicaid, Temporary Assistance for Needy Families, Food Stamps, Child Welfare Services, Childcare subsidies, and Vocational Rehabilitation. The social services and family support programs have become even more essential in light of the economic impact resulting from the COVID-19 pandemic.

Key public-private partnerships continue including:

- Both the Hawaii Maternal and Infant Health Collaborative (HMIHC) and Early Childhood Action Strategies (ECAS) are multi-disciplinary/public-private partnerships working to improve healthy births and child outcomes. FHSD staff serve in leadership positions.
- Child Death Review, Maternal Mortality Review, and Domestic Violence Fatality Review are multi-disciplinary groups that review cases to provide recommendations for prevention efforts.
- The Early Language Working Group makes recommendations to support age-appropriate language development for children age 0-5 years who are deaf, hard of hearing, or deaf-blind.

C.1.e. Operationalization of 5-Year Needs Assessment

Title V staff issue leaders work to evaluate and revise program practice based on outcomes. The leaders work collaboratively across programs and with partners to meet short- and long-term outcomes to support improvements in national and state performance measures that eventually impact the Title V national outcome measures.

5-Year Plan Changes for 2021-2025 (FY 2021)

Several changes in Title V priority selection were made as a result of the 2020 needs assessment; however, further revisions have been made as a result of ongoing needs assessment during the COVID-pandemic and changes in resources and partnerships.

Inactive Priorities/Performance Measures: Three priorities/performance measures will be inactivated in FY 2021. FY 2020 will be the last year of reporting for:

- Children's Oral Health
- Breastfeeding
- Telehealth expansion among Title V programs (state performance measure)

New State Priorities: Four new state priorities were added in FY 2021 as a result of pandemic impacts and new federal funding opportunities. All four priorities address health equity.

- Food Insecurity through WIC services
- Telehealth expansion to underserved communities
- Pediatric Mental Health
- Child Wellness Visits/Immunizations.

Health Equity: Hawaii also integrated a health equity strategy into the plans for any Title V priority without an existing equity component. Activities for the new equity strategies were selected from AMCHP conference presentations, guidance from the MCH Evidence Center (EC), and MCH Workforce Development Center (WDC) skills-building presentations. The activities for these strategies will be refined with closer review of national and local health equity resources and community stakeholder engagement.

Other Plan Changes: Many planned FY 2020 activities were delayed/postponed due to COVID-19. Plans to work with MCH EC and MCH WDC to strengthen planning and evaluation of the five-year plan in FY 2021 were postponed. The lack of epidemiology staff also hindered planning/evaluation initiatives. Several priority strategies, activities, and measures were revised in the five-year plan in response to changing pandemic circumstances/conditions in partnership with community stakeholders. All programs continue ongoing assessment activities to engage stakeholders, families, and youth through the continuing pandemic environment.

Objective Setting: Hawaii did minimal revision of objective setting for selected continuing NPM and SPM since most data in this year's report is from 2019. PM objectives will be re-examined in next year's report when 2020 data is available to determine COVID-19 impacts measures.

C.1.f. Changes in Organizational Structure and Leadership

No organizational changes were made to State or DOH structure; however, several new appointments were made to DOH leadership that are reflected in the DOH Organizational Charts in Section IV of this report. In 2020, Elizabeth Char, M.D., was appointed DOH Director, and in 2021, two new DOH Deputies were appointed by the governor: Kathleen Ho for the Environmental Health Administration and Marian Tsuji for the Behavioral Health Administration.

C.1.g. Emerging Public Health Issues

The COVID-19 pandemic remains a dynamic and ongoing public health priority. The emergence of the Delta variant may provide further challenges to the state's population and healthcare system. FHSD will continue NA data collection, analysis, and dissemination of findings. SSDI funds are being used to help plan/design an MCH data tracker to help compile and quickly review 2020 health and demographic data as it becomes available. FHSD engages with stakeholders, including youth and families, to respond to emerging needs and concerns.

Five-Year Needs Assessment Summary (as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

The Hawaii State Department of Health (DOH), Family Health Services Division (FHSD), conducted a comprehensive needs assessment (NA) that informed FHSD and its state and community partners of the health needs of women, infants, children, and families throughout the State. The NA process examined a variety of primary and secondary data sources, engaged both internal and external stakeholders, and followed a structured and collaborative decision-making process. Findings of the NA guided confirmation of Hawaii's Title V maternal and child health (MCH) priority issues for 2021-2025.

Goal, framework, and methodology

The goal of the NA was to gather a well-rounded picture of the five population health domains, using a comprehensive and inclusive assessment process, so that priority MCH needs could be identified and resources appropriately allocated for the 2021-2025 Title V program cycle.

III.C.2.a(i). The NA framework and process (see Figure 1) were informed by six guiding principles:

- Promote health equity – so that all people and families have the opportunity to attain their highest level of health.
- Consider social determinants of health – the broad social, economic, and environmental factors that must be addressed to promote health and achieve health equity.
- Utilize a life course approach – acknowledges that experiences during critical periods of an individual's life (e.g., infancy, childhood, adolescence, and childbearing age) can have long-term implications.
- Value the roles of our partners and communities – so that our plans and the system of care are family-centered and community-based.
- Utilize evidence-based/informed practices where possible – while also acknowledging the importance of cultural adaptations/tailoring (and evaluation of those adaptations).
- Focus on primary prevention and early intervention – so the system is not only reactionary, but strives to be upstream and prevention-focused.

The framework below illustrates FHSD's NA process and methodologies. Phase 1 included planning and a comprehensive environmental scan, reviewing quantitative and qualitative evidence from a variety of secondary sources. Primary data were collected in Phase 2, where professional and family stakeholders were directly engaged for their feedback on Title V activities and visions for a thriving community. Phase 3 brought all the evidence together for synthesis, planning, and reporting. The process mostly followed the 2015 assessment with some revisions based on evaluative comments received from internal and external stakeholders.

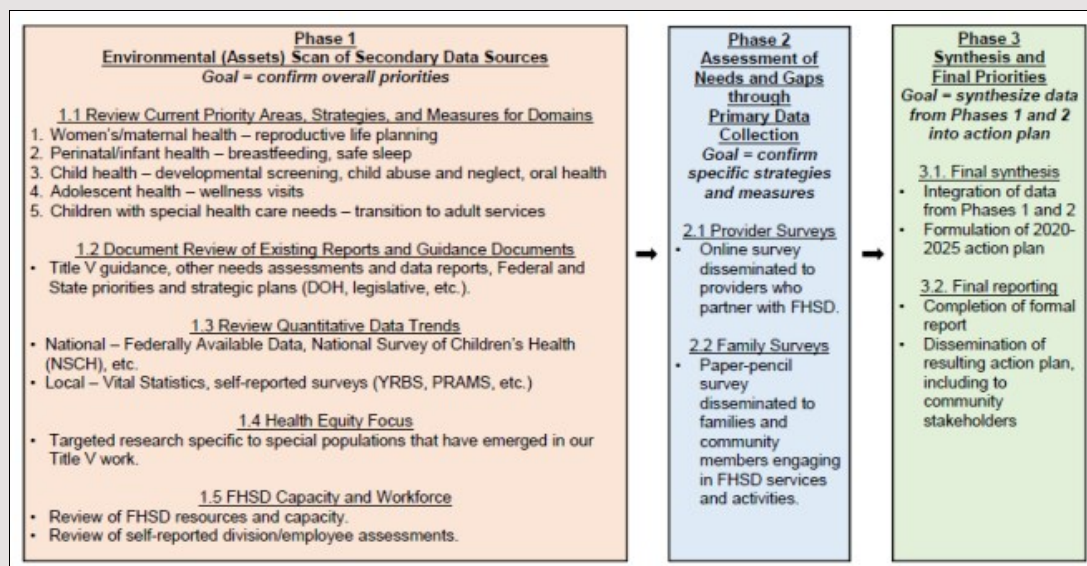


Figure 1. Overview of Hawaii's five-year needs assessment framework and process

The FHSD leadership team oversaw and coordinated the NA process, identification of priority issues and performance measures, and development of the Title V grant report/application. The team included:

- FHSD administration – Chief, Title V coordinator, FHSD Epidemiologists (for data support);
- Chiefs of Maternal and Child Health Branch, Children with Special Health Needs (CSHN) Branch, and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Services Branch;
- FHSD Coordinators on Neighbor Islands;
- Allied programs – Early Childhood Comprehensive Systems, Oral Health; and
- External partners – Family Leader (also Director, Hilopa'a Family to Family Health Information Center), consultation/technical assistance from University of Hawaii at Manoa Public Health and Indices Consulting, LLC.

III.C.2.a(ii). Stakeholder Involvement

Two community surveys – one for providers, and the other for families/community members – were administered to solicit feedback directly from FHSD stakeholders for the specific purpose of informing the five-year NA. Not only were stakeholders participants of these surveys, they also helped to refine and test the data collection tools. The survey design, methodologies, and overall results are described in the “Data Sources” section.

FHSD partners from various backgrounds are engaged through many other ways, as part of the ongoing Title V NA process. These include contributing to the planning, implementation, and evaluation of specific FHSD activities; receiving FHSD activity updates and providing feedback; partnering via allied and cross-agency/disciplinary workgroups. These means of stakeholder involvement are described in greater detail in the “Title V Program Partnerships, Collaboration, and Coordination” section.

III.C.2.a (iii) Quantitative and qualitative methods to assess strengths and needs of population, and capacity of program and partners

A variety of methods were used to gather a broad array of data, to ensure the comprehensiveness of the NA to determine Hawaii's Title V priorities and 5-year plan. The following table lists the methods used, following the order described in the NA framework.

Needs Assessment Component	Type of Method	Description
Phase 1		
1) Review of current priorities, strategies, and measures	Mixed	Collaborate with program staff to reflect on successes and challenges from the previous five years to envision next five years.
2) Document review	Qualitative	Identify, review, and summarize allied community assessments, studies, and strategic plans.
3) Data review	Quantitative	Review and analyze quantitative datasets and measures (local and national sources).
4) Health equity focus	Mixed	Targeted research specific to four special populations that consistently emerge in Hawaii Title V work – COFA (compacts of free association) migrants, immigrants, homeless/houseless, and Native Hawaiians.
5) FHSD capacity and workforce	Mixed	Review of FHSD resources (FTEs, funding) and data from self-reported employee assessments.
Phase 2		
1) Provider surveys	Quantitative, with some qualitative items	Broad-based online survey disseminated to providers who partner with FHSD.
2) Family/community surveys	Quantitative, with some qualitative items	Broad-based paper-pencil survey disseminated to families and community members engaging in FHSD services and activities.

III.C.2.a(iv) Data sources

Phase 1, Component 1 – program reviews with staff

Multiple rounds of small meetings were conducted with program staff to reflect on the successes and challenges from the previous five years and assess opportunities/plans to improve health outcomes. During these meetings, quantitative and qualitative performance data were reviewed, as well as supporting documents such as reports from the MCH Evidence Center. Each program's logic model was also reviewed to identify any necessary changes to strategies, activities, and/or measures.

Phase 1, Component 2 – document review

Major local and national assessments, studies, and strategic plans were reviewed as part of Hawaii's Title V NA process and are detailed in the Supporting Documents. These reports were selected because the planning and/or data collection occurred concurrently with the Title V NA and their mission or scope overlapped with Title V. It was important to be aware of and incorporate these findings to inform the Title V assessment, avoid duplication when possible, and extend the reach of the Title V assessment to include community and professional stakeholders not normally included in Title V assessment efforts.

Phase 1, Component 3 – data review

A variety of secondary quantitative sources informed the NA. The primary sources were:

- Federally Available Data (FAD).
- National Survey of Children's Health (NSCH)
- U.S. Census
- Hawaii Health Data Warehouse (HHDW) including Vital Statistics, Behavioral Risk Factor Surveillance System (BRFSS), Pregnancy Risk Assessment Monitoring System (PRAMS) and Youth Risk Behavior Surveillance System (YRBSS).

Additional data sources are also discussed/identified in other NA phases.

Phase 1, Component 4 – Health Equity Focus

To effectively address health equity in the state, the NA included developing issue briefs on key populations to help inform Title V strategies and plans. Four major communities emerged for additional focus: 1) Compacts of Free Association (COFA) Pacific Island migrants; 2) Immigrants; 3) Homeless/houseless families and youth; and 4) Native Hawaiians. The briefs will be completed in Fall 2020, summarizing quantitative and qualitative data for each group, with the goal of disseminating the information to engage stakeholders in discussions to better serve and work with these communities.

COFA migrants: Post-World War II, the Federated States of Micronesia (Yap, Chuuk, Kosrae, and Pohnpei), the Republic of the Marshall Islands, and the Republic of Palau entered into treaties with the US, known as the Compacts of Free Association (COFA). Under the Compact, COFA migrants are designated as legally residing noncitizen nationals who can freely live, work, and study in the U.S. indefinitely; however, they are not eligible for key entitlement programs (Medicaid, Social Security, disability, and housing programs) with the state assuming most of the costs for services. In 2018, there were approximately 16,680 COFA migrants in Hawaii.

Immigrants: As of 2018, there were 266,147 immigrants in Hawaii, or nearly one-in-five (18.7%) of all residents. This is the 6th-highest of all states. 54.5% are women, and 5.8% are children. There are approximately 45,000 undocumented immigrants in Hawaii (3.3% of the population). The majority are from the Philippines. Hawaii is the only state where women (55%) outnumber men in the unauthorized population. Approximately 7% of K-12 students have at least one undocumented parent.

Homelessness: Hawaii has higher rates of homelessness compared to most other states. In 2020, there were 6,458 homeless people in the State, with the majority on Oahu (4,428), followed by Hawaii County (797), Maui (789), and Kauai (424). After peaking in 2016, homeless rates dropped and have remained consistent since 2018. There are currently 499 homeless family households (76% sheltered, 24% unsheltered).

Native Hawaiians: The Hawaiian people and culture are the indigenous and host community of Hawaii. The Native Hawaiian people have a rich cultural and spiritual base, but also have experienced historical traumas and injustices – all of which contribute to the community's health status.

The Office of Hawaiian Affairs (OHA) is a public agency responsible for improving the wellbeing of Native Hawaiians. Among its activities, OHA tracks data specific to the population publishing the OHA databook and OHA's 2018 *Haumea* report focused on Native Hawaiian Women. Indicators of concern include:

- Native Hawaiian women have the lowest life expectancy (79.4 years) among all females in Hawaii.
- Native Hawaiians have highest rate of infant mortality, 2.3 times greater than Caucasians.
- From 2012-2014, Native Hawaiian mothers of all ages had higher rates of postpartum depression.

Phase 1, Component 5 – FHSD capacity and workforce

In addition to reviewing standard FHSD capacity metrics (e.g., programs, FTEs, vacancies, funding, partnerships, etc.), several other data sources were reviewed related to FHSD's workforce. The sources are described here, and results are discussed in the "Findings" section.

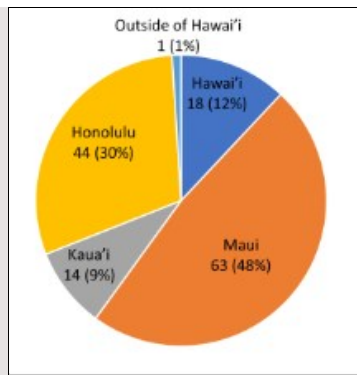
Quantitative surveys:

- FHSD participated in ASTHO's 2017 Public Health Workforce Interest and Needs Survey (PH-WINS). PH-WINS is a national survey of public health agency workers that assesses morale, training needs, and worker empowerment.
- FHSD participated 2019 Council of State and Territorial Epidemiologists (CSTE). nationwide survey to assess states' maternal and child health service capacity during times of crisis/disaster.

Qualitative interviews:

- A 2018 University of Hawaii public health class NA project aimed to inform FHSD's ongoing efforts related to staff training, continuing education, and workforce development. Interviews with health and administrative professionals across the Division were conducted.

Phase 2, Component 1 – provider surveys



Two community surveys – one for providers, and the other for families/community members – were administered to solicit feedback directly from FHSD stakeholders to inform the five-year NA. Survey designs, methodologies, and overall results are described here, and domain-specific results are presented in the “Findings” section. Survey copies are in the Supporting Documents.

The provider survey was distributed to partner agencies and service-providers, via an online (Survey Monkey) format. The list of providers was generated collectively by Title V program leaders, and therefore reflected a broad array of partners across domains, issues, and communities. The link was open from November 2019 to February 2020. The survey had three sections: 1) demographics about the participant and community(ies) they serve; 2) feedback on overall priority areas; and 3) feedback strategies within each priority area. A copy of the provider survey is in the appendix.

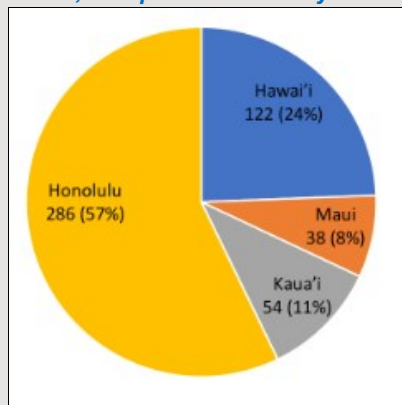
The final email list included 332 stakeholders. A total of 148 completed surveys were received, for a return rate of 45%. The graphs displayed here summarize a few of the demographic variables collected from the participants, including their county of residence.

Providers Surveys – Additional Demographics

(red – top 3 for each questions)

How would you describe the organization/setting you currently work in (select all that apply)?		Which group(s) of people do you serve/ provide services for (select all that apply)?	
State agency	33 (22%)	Women	83 (56%)
County agency	3 (2%)	Pregnant women	82 (55%)
Health center	13 (9%)	Children 0-5 years	105 (71%)
Hospital	12 (8%)	Children 6-12 years	74 (50%)
Private practice	5 (3%)	Teenagers/adolescents	86 (58%)
Insurance provider	3 (2%)	Children with special health care needs	72 (49%)
Childcare provider	10 (7%)	Families	102 (69%)
Youth services provider	11 (7%)	Other	30 (20%)
K-12 education	9 (6%)	• Adults - 5	• Low income/Quest - 4
Higher education	3 (2%)	• Adults with special needs - 4	• Homeless/houseless - 2
Non-profit	63 (43%)	• Single adults - 1	• Trans - 1
Native Hawaiian organization	7 (5%)	• Males - 4	• Permanent residents/allies - 1
Community-based organization	15 (10%)	• Fathers - 1	• Former incarcerated - 1
Faith-based organization	2 (1%)	• Elders - 4	• HS dropout - 1
Other	5 (3%)	• Educators - 2	• Foster youth - 1
Not presently employed	1 (1%)	• Service providers - 2	• “Community” - 3
		• Policymakers - 1	• “Cohort-based” - 1
			• Dental - 1

Phase 2, Component 2 – family/community surveys



The family/community survey was distributed to community members at public events/meetings (e.g., health fairs, community workshops) as well as clients of FHSD services (e.g., WIC clinics). This survey was an abridged version of the provider survey and administered via paper-pencil format. The consumer groups and community events reflected a broad array of people across domains, issues, and communities. The survey was open from September 2019 to January 2020, and had three brief sections: 1) demographics about the participant; 2) feedback on overall priority areas; and 3) a space for open-ended comments.

A total of 500 completed surveys were received. The graph displayed here summarizes the participants' county of residence.

III.C.2.a(v). Interface of data, final priority needs, and development of action plan

The comprehensive NA led to identifying Title V priorities for which the Action Plan was developed. This was the focus of

Phase 3 of the NA – final synthesis, action plan development, and reporting. The process included:

1. Discussion and integration of NA data from Phases 1 and 2.
2. Selection of MCH issues for further review, based on population health domains, link to Title V National Performance Measures (NPM), current State priorities, or emerging issues.
3. Confirmation of overall priority issues, and subsequent confirmation of aligned NPM and other evaluation metrics.
4. Development of the Hawaii Action Plan for the MCH priority issues.

To ensure priority selection was systematic, the following criteria guided the process:

1. Data show needs and challenges. Be information driven (i.e. Hawaii rate worse than the U.S. rate; Hawaii rates worse for specific subgroups, or Hawaii can improve to match the rates of higher performing states.
2. There is community alignment and support. A need may be reflected in other state/community NAs, plans, or initiatives.
3. Viewed through a lens of equity. The process will be open, fair, and equitable. The assessment will be for the State, but will also highlight unique issues for counties, ethnic/cultural groups, and other special populations.
4. Priorities are appropriate for FHSD. FHSD is the lead, or has a major role, and can impact the issue; had the resources (staff, funding) to address the issue.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

This section explores the five population health domains, with respect to health status and the results of the NA surveys that were relevant for each domain. The following table documents when survey participants were asked to reflect on Hawaii's current Title V work, every domain and priority area resonated strongly. Therefore, FHSD could continue work on the current priority areas. Suggestions for possible changes/revisions focused on specific strategies, activities and evaluation measures. The results are still being reviewed for incorporation into future plans.

Title V Needs Assessment Surveys – Current Priorities

(red = top 3 in each column)

	Providers		Community Members
	"There is a strong desire among stakeholders to focus on this priority area."	"Significant progress can be made in this area over the next 5 years."	"How important are these issues to your family?"
	(scale of 4 = strongly agree to 1 = strongly disagree)		(scale of 3 = very important to 1 = not important)
1) Women's wellness check-ups	3.07	3.31	2.89
2) Breastfeeding	3.27	3.38	2.82
3) Safe sleep	3.31	3.39	2.84
4) Developmental screening	3.52	3.55	2.88
5) Children's oral health	3.28	3.43	2.89
6) Child abuse & neglect	3.66	3.49	2.93
7) Adolescent wellness check-ups	3.05	3.28	2.87
8) Transition to adult healthcare	2.88	3.26	2.84
9) Telehealth	3.17	3.39	n/a

Women's health – population domain overview

An estimated 300,000 women aged 15-49 years live in Hawaii, making up 43% of the female population in the state (Census data). The demographic characteristics of this group generally reflect those of the US, except the state's race groupings, which has a high proportion of Southeast Asians, Native Hawaiians and Other Pacific Islanders (NHOPI). Thirty percent of Women of Reproductive Age (WRA) in Hawaii are White, followed by Filipino (20%) and Native Hawaiian (17%), with all other races being less than 10%, respectively. Most WRA are married (46%), heterosexual (90%), a high school or college graduate (31%, respectively), and employed (62%) with an annual household income of \$75,000 or more (36%).

Statewide trends of key health indicators suggest that WRA in Hawaii are engaged in the healthcare system, and their health status is relatively stable (BRFSS data). Among these women, health insurance coverage is at 91%, with approximately 10% having state-sponsored insurance. There was improvement in the percentage of women who had a preventive medical visit (77%) in 2019, exceeding the state objective of 70%. Further, over 80% of women have a routine Pap smear, breast cancer exam, and cervical cancer screening.

Most WRA in Hawaii use conception for family planning. In 2017, 62% of WRA in Hawaii used one or more contraceptive methods during their most recent sexual encounter; however, it was the lowest percentage among all US women (Guttmacher Institute 2017 report). Most WRA in Hawaii are waiting longer to get pregnant, with birth and fertility rates dropping among women in their 20s and rising among women in their 30s and 40s.

High percentages of Hawaii's WRA report having good physical and mental health at nearly 90% and 70%, respectively (BRFSS data). However, almost 18% have two or more chronic conditions, and 15% have at least one physical or mental disability. About 51% are current drinkers, and 21% are binge drinkers. Tobacco use is also common among this subgroup – 15% are current cigarette smokers, and 8% are current e-cigarette (vape) users.

Although Hawaii's WRA are generally healthy, significant differences within racial and ethnic subgroups remain. High-risk groups include low income individuals, younger women, and NHOPIs. Rising trends in obesity and risky health behaviors, particularly younger women, suggest a need for a more statewide focus on their health needs as well as targeted women's health interventions and programs for this subgroup.

Pregnant women & Infant health – population domain overview

Each year, there are about 18,000 births to Hawaii residents, which remained stable for the past decade (ACS data). In 2018, Hawaii's birth rate was 11.9 per 1,000 for women aged 15–44 years (similar to the national rate of 11.6) and was highest among those aged 30–34 years (97.9) and 25–29 years (95.9) (NCHS data). Among teen mothers aged 15–19 years, the birth rate is 17.2 per 1,000, which was similar to the U.S rate of 17.4, and highest among NHOPIs.

According to 2012–2015 aggregate PRAMS data, most live births occurred to women who were Asian (31%), Native Hawaiian or part-Hawaiian (28%), White (24%), Filipino (17%), and other races were at 5% or less. Over half (56%) of women had an annual household income at or above 185% of the federal poverty level, suggesting economic stability. Further, most women were married (69%), had private health insurance coverage (52%), and had one or more previous births (66%). Some women relied on state assistance around the time of pregnancy, with 27% having public health insurance and 42% being WIC participants. Statewide 2018 PRAMS data showed that 72% of women initiated prenatal care in the first trimester of pregnancy, which was a significant decrease from 2015 when it was 77% (FAD data). Pregnant women less than 20 years of age, uninsured or on Medicaid, with a high school education or less, and NHOPIs were less likely to start early prenatal care.

In 2017, severe maternal morbidity was 82.6 per 10,000 hospitalizations in Hawaii, which was not significantly different from the U.S. rate of 70.9 (FAD data). However, among their infants, the rate of infants dying before their first birthday is trending upward over the past five years. The infant mortality rate in Hawaii fluctuated since 2011 from 5.3 deaths per 1,000 live births, to 6.8 in 2018, with a significant increase between 2014 (4.5) to current. This upward trend is concerning because it surpassed the Healthy People 2020 objective (6.0).

Breastfeeding, or at least breastfeeding initiation, is common in Hawaii and is essentially unchanged for eight years. In 2016, 89% of infants were ever breastfed (FAD data). A lesser proportion of mothers continue to breastfeed exclusively through six months at 33%; however, it is higher than the U.S. estimate (25%). The latest 2016 PRAMS data showed that 78% of infants are placed on their backs to sleep, but only 20% are placed on an approved sleep surface, and 32% are placed to sleep without soft objects or loose bedding. Disparities in infant safe sleep practices exist for mothers who were 20 years or younger, at or below the 185% of the federal poverty level, and Native Hawaiian.

An assessment of Hawaii's maternal and child health indicators suggest that pregnant women and their infants are faring as well as those nationwide. However, there are observed differences between subgroups that require close examination and

focused public health efforts. These data show that health disparities are commonly highest among low-income individuals, younger mothers, those with a high school education or less, and those who are uninsured or on public insurance. Racial variations exist depending on the indicator, but in general, poorer outcomes are experienced by NHOPI and Blacks.

Child health – population domain overview

In Hawaii, there are approximately 300,000 children under 18 years old, roughly 21% of the total population (Census data). Since 2012, there is a steady decline in the percentage of children under 18 years old. About 31% are classified as being of two or more races (31%), followed by Asian (24%), White (14%), NHOPI (11%), and all other races less than 5%. The economic well-being of Hawaii's children improved since 2010, with fewer children in poverty (12% in 2018 vs. 14% in 2010), and fewer children whose parents lack secure employment (26% in 2018 vs. 30% in 2010) (Kids Count data). A lower percentage of children in Hawaii (30%) live in single-parent households compared to all U.S. children (35%) (Kids Count data).

The *2020 Kids Count Data Book* ranks Hawaii 17th in overall child well-being among all U.S. states. Further, the state ranks 7th in the nation for child health and has shown improvements in several key indicators, such as insurance coverage and child mortality. Hawaii's child mortality rate decreased among those aged 1 through 9 years, from 18.2 per 100,000 in 2018, to 13.3 in 2019 (FAD data). Also, there was a significant decline in hospitalizations for non-fatal injury for children aged 0–9 years at 77.4 per 100,000 in 2019 from 99.7 in the previous year—this rate is significantly below the national rate of 128.6 (FAD data).

Most of Hawaii's young children do not receive developmental screening needed to identify and diagnose unmet behavioral and learning milestones. Data from 2017–2018 showed that 36% of children ages 9 through 35 months in Hawaii received a developmental screening in the past year. But, most children in Hawaii access preventive services, including immunizations; however, there are health inequities by age group and race. In 2019, 86% of children aged 1–17 years had a preventive dental visit within the past year (FAD data). However, routine oral health care is markedly lower among children between 1 and 5 years (72%) compared to older age groups.

Other indicators suggest Hawaii's children have challenges related to maintaining a healthy lifestyle. Among children aged 10–17 years, 12% were considered obese; though this is lower than the U.S. estimate (15%), it highlights a need for better nutrition and more physical activity. Among children aged 6–11 years, less than a quarter (21%) were physically active for at least 60 minutes per day in Hawaii, which was lower than the national average (28%). Safety of the State's youngest children continues to be a community concern. The 2019 rate of confirmed child abuse and neglect cases per 1,000 children aged 0 to 5 years is 5.5.

Taken together, Hawaii's children are relatively healthy, and there are positive trends across several key indicators of child health. However, there are disparities in oral care and vaccination rates as well as a high prevalence of childhood obesity. High-risk groups for selected key indicators include low income individuals, younger children, non-Hispanic Whites, and NHOPIs.

Adolescent health – population domain overview

There are an estimated 164,000 adolescents in Hawaii; of those, 84,000 aged 10–14 years and 78,000 aged 15–19 years (Census data). The racial and ethnic profile of adolescents in Hawaii suggests that most are of two or more races, NHOPI, or Asian.

Trends of several health indicators suggest that adolescents in Hawaii are as healthy as most U.S. adolescents. Still, there are health disparities that lead to worse outcomes for certain subgroups. According to data from 2016–2018, 75% of adolescents ages 12–17 years had a preventive medical visit within the past year, which met the 2019 state objective (FAD data). However, adolescents with college-educated parents were more likely to have a preventive visit compared to those whose parents who had completed some college or below; similar differences exist for low-income individuals and non-English language speakers.

Like the U.S. overall, two of the leading causes of adolescent mortality in Hawaii are unintentional injuries, such as motor

vehicle-related injuries, and suicide, which is classified as an intentional injury. In 2018, the overall mortality rate for adolescents aged 10–19 years was 25.1 per 100,000, but this estimate was not significantly different from the U.S. estimate (32.2) (FAD data). Data from 2016 to 2018 showed that males had a noticeably higher mortality rate (36.4) than females (19.4), but there were no significant differences across racial groups. YRBS data revealed some insight into potential factors affecting both motor vehicle-related deaths and deaths by suicide among adolescents. It showed that 38% of high school students text while driving a motor vehicle. Also, 30% of high school students had depression within the last 12 months, and 10% attempted suicide resulting in injury or treatment.

The percentage of Hawaii's adolescents who are engaging in sexual activity remains stable, but their practices of good sexual health seem to be improving. In 2017, 19% of high school students were currently sexually active, with 64% using some form of birth control (YRBS data). A high percentage of adolescents in Hawaii are getting vaccinated against HPV, compared to the U.S. overall. Births among females ages 15-19 in the state reduced significantly from 33.0 per 1,000 in 2010, to 17.2 in 2018, and was similar to the U.S rate at 17.4 (FAD data). However, there are racial variations with NHOPIs and those of multiple races having higher teen birth rates.

There is an observed shift in trends in tobacco use from smoking cigarettes to e-cigarettes (vaping). In 2017, 23% of high school students reported smoking cigarettes; however, almost double (42%) were vaping (YRBS data). Current e-cigarette use is significantly higher among Hawaii's adolescents than those nationwide (13%).

Adolescents in Hawaii face some health challenges, but in general, maintain overall good health status. There are observed disparities among low-income individuals, non-English language speakers, NHOPIs, those of two or more races, and those in households with parents who have some college education or less.

Children with special health needs (CSHN) – population domain overview

According to data from the 2017–2018 National Survey of Children's Health (NSCH), 13% of children ages 0-17 years in Hawaii have special needs, compared to the national estimate of 18%. Almost half (49%) are classified as other race, followed by Asian (17%), White (12%), Black (1%), and 21% Hispanic/Latino (NSCH). There is no significant difference in race and ethnicity between CSHN and children without special health needs in the state. Among CSHN, there are more males (61%) than females—a trend that is also observed nationally. A high percentage of CSHN (98%) have health insurance, with 66% using primarily private insurance for medical services and 27% using public insurance. Most CSHN live in two-parent households (66%), have at least one adult in the home with a college degree or higher (49%), and live in a home with an annual income at 200-399% of the federal poverty level (43%), suggesting some economic stability. Despite these demographic similarities, each family with a CSHN has its unique challenges and concerns because of the different types of special needs a child can experience.

Receiving adequate medical care and being in home and school environments that are free of neglect and abuse are essential to each child's development. From 2017 to 2018, nearly half (45%) of CSHN ages 0-17 in Hawaii had a medical home, which was similar to the national estimate (43%) but lower than the Healthy People 2020 objective (52%) (FAD data). Among this group, a relatively small percentage (17%) are in a well-functioning system of care that integrates a family-centered home with comprehensive needs-specific medical attention; however, this percentage is similar to those nationwide (14%). During the same period, among children ages 3-17 with a mental or behavioral condition, 54% received treatment or counseling, suggesting that most children acquire the psychological care they need, but there is room for improvement.

Of concern, 2017-2018 data show that only a quarter of adolescents with and without special health care needs, ages 12 -17 years, received services needed to make transitions to adult health care (24.7%).

Based on key health indicators, most CSHN in Hawaii are adequately insured and live in households that are conducive to having access to medical care and treatments tailored to their health needs or disability. Although the small number of CSHN in the state did not allow for examining differences by demographic characteristics, disparities may exist in specific vulnerable populations, such as low-income individuals and NHOPIs.

Survey results for the five domains

Provider surveys included a section for participants to offer input on Title V priority strategies and activities. For each national and state performance measure, participants were provided with the current strategies and asked, “Are these the right/best strategies for Hawaii to focus on in the next five years?” Participants were allowed to provide comments on the existing strategies or suggest new ones. The following table summarizes the feedback for all the NPM strategies across the five population domains.

Domain	NPM and current strategies	Are these the right/best strategies?	Categories of open-ended comments
Women	Promoting wellness check-ups for women. <ul style="list-style-type: none"> • Use evidence-based strategies including One Key Question, to engage women in reproductive health planning. • Expand access to long-acting reversible contraception. 	Yes = 128 (86.5%) No = 15 (10.1%) Blank = 5 (3.4%)	<ul style="list-style-type: none"> • Support for/expansion of OKQ and LARC. • Suggestions on encouraging women to go to their check-ups, and for providers when conducting visits. • Reducing insurance and financial barriers. • Important sub-populations (e.g., LGBTQ+, youth, women with mental health concerns, etc.).
Infants	Promoting breastfeeding & supports for new mothers <ul style="list-style-type: none"> • Partnering with Women, Infants & Children (WIC) programs. • Working with the Hawaii Maternal & Infant Health Collaborative to implement the State Breastfeeding Strategic Plan. 	Yes = 130 (87.8%) No = 15 (10.1%) Blank = 3 (2.0%)	<ul style="list-style-type: none"> • Access to lactation consultants and supports (e.g., at hospitals), including those who don't qualify for WIC. • Programs such as provider

			<p>education and establishing a milk bank.</p> <ul style="list-style-type: none"> • Policy issues (e.g., insurance coverage for breastfeeding supports, workplace culture). • Incorporation of cultural practices, and family-based approaches (not just targeting mothers). 	
Infants	<p>Promoting safe sleep for infants.</p> <ul style="list-style-type: none"> • Expanding outreach to non-English speaking families. • Ongoing data surveillance. • Workforce training (e.g., through annual Safe Sleep Summit). 	<p>Yes = 132 (89.2%)</p> <p>No = 10 (6.8%)</p> <p>Blank = 6 (4.1%)</p>	<ul style="list-style-type: none"> • Expansion of outreach efforts (e.g., home visiting, targeting non-English-speaking families). • Education for families. • Allied programs (e.g., cribs for kids). 	
Children	<p>Early screening of children for developmental delays.</p> <ul style="list-style-type: none"> • Developing family-friendly messaging. • Working with early childhood providers to ensure systematic efforts for screening, referral to services, and follow-up. 	<p>Yes = 121 (81.8%)</p> <p>No = 20 (13.5%)</p> <p>Blank = 7 (4.7%)</p>	<ul style="list-style-type: none"> • Brining screening to various settings (e.g., schools, doctors' offices, early childhood providers, etc.). • Ensuring appropriate services are available if/when identified through screening. 	

			<ul style="list-style-type: none"> Continue to build systems and collaborations around screening. 	
Children	Promoting oral health among children. <ul style="list-style-type: none"> Maintaining data surveillance. Promoting greater access to prevention services (e.g., through teledentistry). Supporting coalition-building and community planning efforts. 	Yes = 120 (81.1%) No = 22 (14.9%) Blank = 6 (4.1%)	<ul style="list-style-type: none"> Addressing dietary habits and choices (e.g., beverage choices in schools). Expanding partnerships (e.g., PCPs, mobile outlets, schools, teledentistry). Policy issues such as expanded insurance coverage, cost of living (expensive to eat healthy), water fluoridation. 	
Children	Child abuse and neglect prevention <ul style="list-style-type: none"> Supporting home visiting services. Continuing outreach and education (e.g., parent supports, community education, workforce trainings). Building a child abuse and neglect data system. 	Yes = 123 (83.1%) No = 22 (14.9%) Blank = 3 (2.0%)	<ul style="list-style-type: none"> Further engaging parents and families (e.g., addressing parental stress, support services, etc.). Further training for providers. Improvement of current CWS infrastructure and CAN data/tracking system. Allied services such 	

			as home visiting and substance use programs. <ul style="list-style-type: none"> • Need to address economic and policy challenges. 	
Adolescents	Promoting adolescent annual medical wellness check-ups. <ul style="list-style-type: none"> • Developing a teen-centered Adolescent Resource Toolkit and incorporating youth voice through focus groups. • Workforce training for youth service providers and community health workers. 	Yes = 126 (85.1%) No = 13 (8.8%) Blank = 9 (6.1%)	<ul style="list-style-type: none"> • Expansion of outreach and programs in the school setting. • Suggestion of related topics such as mental health, resilience, and coping skills. • Suggestions for partnerships with allied services (e.g., teen clinics, rural health, LGBTQ+, etc.). 	
Children with special health needs	Ensuring children transition smoothly to adult health care <ul style="list-style-type: none"> • Incorporating transition planning into Children with Special Health Needs programs. • Working with agency partners for community outreach (e.g., through transition fairs). 	Yes = 120 (81.1%) No = 18 (12.2%) Blank = 10 (6.8%)	<ul style="list-style-type: none"> • Expansion of transition planning to other settings (e.g., medical homes, schools). • Increasing education for the child and family. • Continuing to build systems and programs to support and complement transition. 	

III.C.2.b.ii. Title V Program Capacity

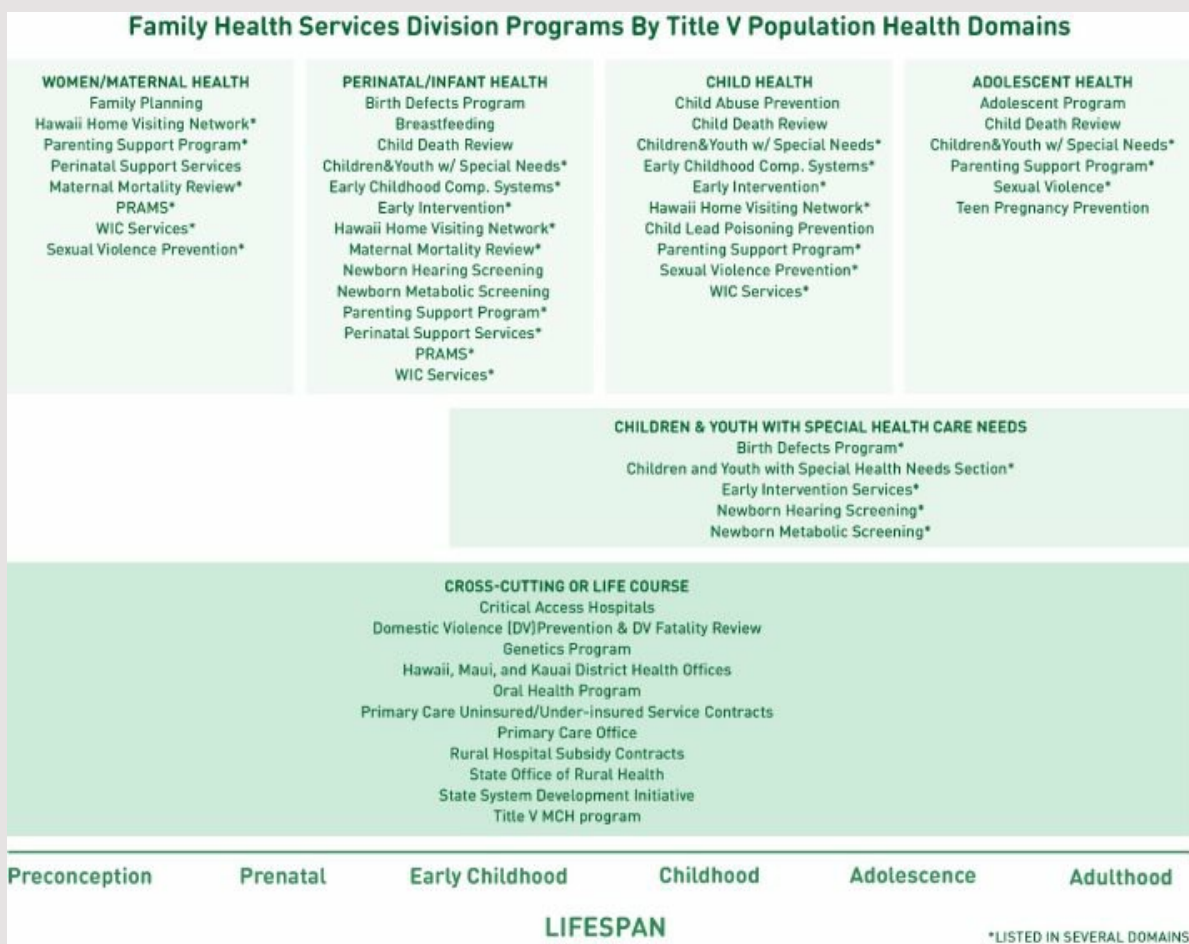
III.C.2.b.ii.a. Organizational Structure

The Hawaii State Department of Health (DOH) is a major administrative agency of the Hawaii State Government, with the Director of Health appointed by and reporting directly to the Governor (see Figure 2). DOH has three administrations, including the Health Resources Administration (HRA). Divisions within HRA include FHSD, which is responsible for administration of Title V funding. FHSD houses the MCH, CSHN, and WIC Branches, and the Office of Primary Care and Rural Health, all of which are codified within the Hawaii Revised Statutes. Organizational Charts for the Executive Branch of State Government, DOH and FHSD are in report Section IV Organizational Chart).

III.C.2.b.ii.b. Agency Capacity

Title V is considered the “umbrella” for FHSD’s work to improve the health of women, infants, children and adolescents, and other vulnerable populations and their families. FHSD’s working principles are to: be data-driven; monitor outcomes and impacts via evaluation; use evidence-based and best/promising practices; engage with the community; examine systems, policy development, and environmental change; use a life course approach; and consistently look at quality improvement.

FHSD programs work to ensure statewide infrastructure for data collection, NA, surveillance, planning and evaluation, systems and policy development, monitoring, provision of training, and technical assistance to assure quality of care. Thus, FHSD can address each of the population health domains through its many programs (see figure below).



III.C.2.b.ii.c. MCH Workforce Capacity

FHSD has 283 FTE staff, of which 21.15 FTE are Title V-funded, and 44 FTE are located on Neighbor Islands.

	Total FTE (all funding sources)	Title V FTE*	Hawaii FTE	Maui FTE	Kauai FTE
FHSD Administration	30.0	4.5	2.0	3.0	2.0
MCH Branch	35.0	8.6	1.0	0	0
CSHN Branch	149.0	8.05	6.0	3.0	3.0
WIC Branch	69.0	0	13.0	7.0	4.0
TOTAL	283.0	21.15	22.0	13.0	9.0

*Includes vacant positions.

FHSD's administration, branches, and programs include:

FAMILY HEALTH SERVICES DIVISION: Matthew Shim, PhD, MPH. Dr. Shim holds degrees in Psychology, Public Health, and a Doctorate in Epidemiology. He has served as Division Chief since 2016.

CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH: Patricia Heu, MD, MPH, pediatrician, has served as Branch Chief since 1997.

MATERNAL AND CHILD HEALTH BRANCH: Kimberly Arakaki, MSCP, has served as Branch Chief since 2016, and prior to that was the DOH Case Management and Information Services Branch Chief from 2007. She has nearly 30 years of experience working with individuals with developmental disabilities and their families.

WIC SERVICES BRANCH: Melanie Murakami, MPH, RDN, has been with the Branch since 2000, and has served as WIC Director and Branch Chief since 2018.

DISTRICT HEALTH OFFICES (DHOs): DOH programs on the Neighbor Islands are administered by three DHOs for Hawaii, Maui, and Kauai Counties. Each DHO has a Family Health Services Coordinator (Registered Nurse) responsible for FHSD services (Children with Special Health Needs, Early Intervention, Maternal and Child Health, WIC). Each office may have other responsibilities and projects/activities specific for their communities (e.g., Maui DHO oversees program staff for the federal ECCS grant).

TITLE V FAMILY LEADER: Leolinda Iokepa is the Director for Hilopaa F2FHIC; Co-Director for Hawaii's MCH LEND Program; Coordinator for Family Voices of Hawaii; AMCHP Family Delegate and a parent of a young adult with special needs. She is active in the NA process and planning of Title V MCH/CSHCN priorities and FHSD activities over the past 15 years.

ROLE OF PARENTS: Parents serve on advisory boards and as program consultants, and in the case of WIC, as paid peer breastfeeding counselors. Family input is sought through surveys including client service satisfaction and other types of input (see Family Partnership section).

Several other quantitative and qualitative data sources were reviewed related to FHSD's workforce status and needs. The sources were introduced in the "Data Sources" section, and the results are discussed here.

Quantitative surveys:

ASTHO's Public Health Workforce Interest and Needs Survey (PH-WINS) – The most recent data available for FHSD are from 2017. A total of 916 Hawaii DOH employees completed the survey. Of those, 30 (3.3%) were from FHSD. While there are data limitations, the Division's major results are summarized below:

- 25% reported having plans to retire by 2023, another 31% were considering leaving within the next year for reasons other than retirement.
- 87% reported satisfaction with their job, but only 59% were satisfied with the organization and 50% were satisfied with their pay.
- The top three training needs for both supervisory and non-supervisory staff were budget and financial management (63%), systems and strategic thinking (63%), and change management (60%).

Recommendations included succession-planning, investing in training for the existing workforce, workplace policies/practices that support job satisfaction and improve retention, and improving employee engagement.

Council of State and Territorial Epidemiologists (CSTE) – In 2019, FHSD participated in CSTE's nationwide survey to assess states' MCH service capacity during a time of crisis/disaster. At the time of the survey, two full-time epidemiologists were affiliated with FHSD. They are generally supported by the larger DOH and external partners but may not be routinely

activated during preparedness drills and activities. However, this may be reflective of the funding supporting each position (e.g., funding may be specific to evaluation of FHSD programs).

Qualitative interviews:

In fall 2018, a University of Hawaii graduate public health class conducted a NA project to inform FHSD's efforts related to staff training and workforce development. The students conducted 14 interviews with health and administrative professionals across the Division representing a range of positions and backgrounds. The findings are summarized below:

- Current training opportunities within FHSD are either standardized (e.g., HR requirements) or highly specific to the responsibilities and subject matter of staff or units. Current trainings were valuable, but also time-consuming and expensive. Additionally, challenges with dissemination of opportunities, as well as format, were found to limit participation. A few of the standardized trainings emerged as opportunities for coordinated division-wide growth, if redesigned/redeveloped.
- There is a need to build public health competencies at all staff levels. Many employees come from a clinical or service delivery background, often with degrees in social work, psychology, or a related field. While these experiences are valuable, these professionals may be unfamiliar with core public health concepts such as the social determinants of health, research methods, data analytics, and epidemiology. Interviewees also stressed the importance of building strategic and cross-cutting skills, including leadership training opportunities. Several managers expressed that it can be difficult to gauge leadership skills in the hiring process and challenging to teach these skills on the job. Other identified areas for skills-building included budgeting, project management, policy engagement, data translation, and communication.
- The interviews also revealed some challenges with recruitment into the workforce. For example, there is no clear pathway for recent MPH graduates to enter lower-level positions, which is a barrier for cultivating the next generation of public health professionals.

In summary, workforce needs and challenges for FHSD and Title V include:

- Vacancies in key epidemiology positions, including the CDC MCH Epidemiology Assignee.
- Difficulty in filling Title V-funded positions, due to insufficient Title V funding. There has not been an increase in Title V funding to correspond with salary increases.
- Difficulty in requesting new State general-funded positions due to State economic concerns.
- Strengthening Division-wide organizational identity, culture, and infrastructure to improve communications, collaboration, employee engagement, and other workforce needs.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

In addition to the two community surveys, stakeholders from various backgrounds are engaged through other means:

- All Title V programs engage with specific community partners in the delivery of services and implementation of activities. Some of these collaborations are formalized (e.g., MOAs and MOUs), while others are informal (e.g., partners provide content area expertise). In addition, several programs solicit feedback from partners to inform planning, implementation, and evaluation of their strategies and activities.
- Collaboration often occurs across FHSD and Title V programs. Efforts in recent years were made to leverage resources and connections across programs and streamline service delivery and communication.
- Community partners are engaged via cross-agency/system workgroups or taskforces. FHSD convenes and/or provides leadership for some of these groups.
- Many FHSD partners participated in other NA studies within the last several years and expressed their priorities, strengths, needs, and limitations. FHSD incorporated these findings, given how broadly family health intersects with other public health issues, and to avoid overburdening partners and the general community with multiple assessments. Therefore, other organizations' NAs and strategic plans are considered, as discussed in the "Data sources – Phase 1, Component 2 – document review" section, and detailed in the Supporting Documents.

The following table captures the broad array of FHSD program partnerships and collaborations over the past five years by Title V population domains.

					Children
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	Women's Health	Infant Health	Child Health	Adolescent Health	with Special Health Needs
Programs within Department of Health (not including FHSD and Title V programs)					
Chronic Disease Branch				x	
Developmental Disabilities Division			x		x
EMS and Injury Prevention System Branch		x		x	
Other local government-affiliated organizations					
Department of Education		x	x	x	x
Department of Human Services (e.g., Medicaid program; Office of Youth Services)	x	x	x	x	x
Executive Office on Early Learning (including Early Head Start and Head Start programs)	x	x	x		
Hawaii National Guard's Youth Challenge Academy					
Hawaii State Council on Developmental Disabilities					x
Office of Language Access		x			
University of Hawaii at Manoa – John A. Burns School of Medicine	x	x	x	x	x
University of Hawaii – Maui College			x		
University of Hawaii at Manoa – Office of Public Health Studies	x	x	x	x	x
University of Hawaii at Manoa – School of Nursing and Dental Hygiene	x	x	x		
Healthcare organizations (hospitals, clinics, insurance carriers)					
Adventist Health Castle		x			
AlohaCare Insurance			x		
Bayada Home Care	x	x			
Federally Qualified Health Center network (coordinated by the Hawaii Primary Care Association)	x	x	x	x	x
Hawaii Community Genetics Clinics					x
Hawaii Dental Association			x		
Hawaii Dental Hygiene Association			x		
Hawaii Dental Service			x		
Hawaii Maternal Child Health Leadership Education in Neurodevelopmental & Related Disabilities (MCH-LEND)					x
Kaiser Permanente		x			x
Kapiolani Medical Center for Women and Children	x	x			
Kona Community Hospital	x	x			
Queen's Medical Center		x			
Shriners Hospital for Children		x			
Tripler Army Medical Center	x	x			

	Women's Health	Infant Health	Child Health	Adolescent Health	Children with Special Health Needs
Waianae Coast Comprehensive Health Center		x			
West Hawaii Community Health Center			x		
Wilcox Medical Center		x			
Professional organizations					
American Academy of Pediatrics – Hawaii Chapter	x	x	x	x	x
American College of Obstetricians and Gynecologists – Hawaii Chapter	x	x			
Community-based organizations, non-profits, and networks					
Aging and Disability Resource Center					x
Best Buddies Hawaii					x
Breastfeeding Hawaii	x	x			
Child and Family Services		x			
Children's Community Councils		x	x		x
Coalition for a Drug-Free Hawaii				x	
DentaQuest Foundation			x		
Early Childhood Action Strategy	x	x	x		
Family Hui Hawaii	x	x	x		
Family Support Hawaii	x				
Hawaii Children's Action Network	x	x	x	x	x
Hawaii Community Foundation			x		
Hawaii Health Data Warehouse	x	x	x	x	x
Hawaii Health Survey Committee				x	
Hawaii Maternal and Infant Health Collaborative	x	x	x	x	x
Hawaii Mothers Milk	x	x			
Hawaii Oral Health Coalition			x		
Hawaii Partnership to Prevent Underage Drinking				x	
Hawaii Project Extension for Community Healthcare Outcomes (ECHO)		x			
Hawaii Public Health Institute	x	x	x		
Hawaii Youth Services Network				x	
Healthy Mothers Healthy Babies	x	x			
Hilopaa Family-to-Family Health Information Center	x	x	x	x	x
Institute for Human Services		x			
Keiki Injury Prevention Coalition		x			
La Leche League	x	x			
Legislative Disability Forums					x
March of Dimes	x	x			
Mental Health America of Hawaii				x	
PATCH (people attentive to children)		x			

	Women's Health	Infant Health	Child Health	Adolescent Health	Children with Special Health Needs
Perinatal Action Network	x	x			
Perinatal Nurse Managers Task Force		x			
Prevent Suicide Hawaii Taskforce				x	
Safe Sleep Hawaii		x			
Special Olympics					x
Special Parent Information Network					x
Youth Tobacco Prevention Coalition				x	
National agencies (not including HRSA)					
Centers for Disease Control and Prevention	x		x		
Department of Agriculture	x	x			
National Association for the Education of Young Children		x			
Office of Adolescent Health				x	
US Breastfeeding Coalition	x	x			

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Identifying priorities and linking to measures

Phase 3 of the NA brought together the findings from the secondary data sources, unique needs reported by stakeholders, and the agency capacity of FHSD. Four criteria guided the priority selection process:

1. Data show needs and challenges
2. There is community alignment and support
3. View through a lens of equity
4. Priorities are appropriate for FHSD

The NA confirmed that FHSD should continue to build on the progress made to date on the current priority areas, but improvements could be made on strategies, activities, and measurement of outcomes/impacts.

As each priority area and its strategies/activities were confirmed, measures were selected which aligned with the inputs (resources and activities) and desired outcomes. Logic models were developed for each priority area to guide this alignment process (drafted during the 2015-2020 grant cycle and updated during the current NA). The logic model organizes the components of a project including resources, activities, and outcomes/impacts, in addition to showing the interactive relationships among components. *Resources* are the assumptions underlying a program, and the necessary infrastructure for implementation. *Strategies/Activities* were developed with feedback from stakeholders, and when implemented, result in *Short-Term Outcomes* (including the Strategy Measure). *Longer-Term Outcomes* (including the National Performance Measure and National Outcome Measures) refer to the intended effects of cumulative program components and describe the targeted population and system changes for each program. *Contextual Conditions* refer to considerations such as culture, rurality, health and service gaps, and socioeconomic conditions that must be considered as we work to engage stakeholders and develop/implement the program components.

Hawaii will continue to engage stakeholders and technical assistance to evaluate and revise the five-year plan to assure the effectiveness of the strategies selected.

Changed and emerging issues/needs

During the 2015-2020 funding cycle, Hawaii's Title V program included telehealth and children's oral health as priorities. Developing telehealth capacity across Hawaii Title V programs was a state performance measure which achieved substantial

success over the last five-year period. Consequently, this priority will not be carried into the 2021-2025 funding cycle. Staff and stakeholders are grateful for the telehealth infrastructure put into place, especially given the recent move to online/virtual activities during the pandemic. Telehealth activities will now be incorporated into the remaining Title V priorities.

Children's oral health will continue through general support and collaboration with external organizations but will not be a formal Title V priority for the next funding cycle. Since completion of the Centers for Disease Control and Prevention (CDC) oral health infrastructure grant in August 2018 and no continued availability of program funding, FHSD does not have the resources needed to advance statewide efforts. FHSD will continue to partner with oral health stakeholders through the State Oral Health Coalition and will continue to seek funding to rebuild the state oral health program.

Several data sources from the NA highlighted new and/or emerging issues, including mental health, behavioral health, substance use, bullying prevention, and housing. While these topics are important for the State MCH population and have direct impact on Title V work, FHSD is not the state-designated lead for these issues. Therefore, FHSD will actively collaborate with the appropriate point-of-contacts for these topic areas including:

- DOH Behavioral Health Administration that includes child/adolescent mental health, adult mental health, and alcohol and drug abuse,
- DOH Emergency Management Services and Injury Prevention System Branch that includes violence, injury, and suicide prevention, and
- the Department of Human Services, state leader for homelessness, to support child and family health services and initiatives.

FHSD will continue NA efforts including data analysis, publication and dissemination of data findings, and engagement of stakeholders including youth and families to respond to emerging needs and concerns.

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$1,989,226	\$1,882,488	\$2,394,340	\$2,027,508
State Funds	\$28,414,686	\$27,324,746	\$28,350,378	\$28,133,440
Local Funds	\$0	\$0	\$0	\$0
Other Funds	\$63,078	\$0	\$0	\$0
Program Funds	\$16,422,876	\$11,056,301	\$13,205,575	\$7,672,215
SubTotal	\$46,889,866	\$40,263,535	\$43,950,293	\$37,833,163
Other Federal Funds	\$49,970,074	\$39,143,194	\$51,294,329	\$38,374,744
Total	\$96,859,940	\$79,406,729	\$95,244,622	\$76,207,907
	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$2,077,106	\$2,055,426	\$2,083,027	
State Funds	\$31,499,929	\$26,944,383	\$31,499,929	
Local Funds	\$0	\$0	\$0	
Other Funds	\$203,441	\$49,934	\$0	
Program Funds	\$13,584,510	\$8,622,714	\$18,439,145	
SubTotal	\$47,364,986	\$37,672,457	\$52,022,101	
Other Federal Funds	\$45,765,848	\$30,928,565	\$37,230,305	
Total	\$93,130,834	\$68,601,022	\$89,252,406	

	2022	
	Budgeted	Expended
Federal Allocation	\$2,319,160	
State Funds	\$29,759,413	
Local Funds	\$0	
Other Funds	\$0	
Program Funds	\$18,474,919	
SubTotal	\$50,553,492	
Other Federal Funds	\$40,729,830	
Total	\$91,283,322	

III.D.1. Expenditures

The State maintains budget documentation for all Block Grant funding allocations and expenditures for tracking and reporting. All expenses are tracked through the state accounting system, *Datamart*, which captures and details all federal and non-federal spending reflected in the state fiscal year (SFY).

2020 Expenditures for the application year FY 2022:

The Hawaii State Department of Health (DOH), Family Health Services Division (FHSD) functions to promote and provide services statewide for women of childbearing age, infants, and children. FHSD consistently strives to make a positive difference in the lives of women, children, and families throughout the state of Hawaii. With approximately 280 employees, these services are carried out by the administrative and consultant staff at the division office and through three FHSD Branches. Consisting of approximately 30 programs, FHSD works to promote and improve the health and well-being of Hawaii's mothers and children (including CSHCN) and their families. This grant application describes how the budget and expenditures align to support FHSD programs, including the Title V priorities, to improve the health of the state's MCH population.

Overview of FHSD Programs

As noted earlier, the DOH is the only public health agency in the state. Thus, unlike most states, FHSD must provide all levels of service delivery: direct, enabling, and infrastructure building for all state counties and municipalities. As one of the largest divisions in DOH, FHSD's three branches—Maternal and Child Health Branch (MCHB); Children with Special Health Needs Branch (CSHNB); and Women, Infants and Children (WIC)—together addressed this need with a FY 2020 Program Income, which amounted to \$13.6 million with same year expenditures of \$8.6 million. This income is managed through five state special funds that include the following:

- Newborn Metabolic Screening Special Fund (funded by reimbursements for newborn screening test kits)
- Birth Defects Special Fund (funded with \$10 from each marriage license fee)
- Domestic Violence and Sexual Assault Special Fund (funded from a percentage of fees generated from birth, marriage, and death certificate fees)
- Community Health Centers Special Fund (funded through a portion of cigarette taxes)
- Early Intervention Special Fund (funds received through Medicare, Tricare, and the Random Moments Survey)
- State Agency transfer 'U' fund (funds received from other state agencies, such as the Department of Human Services that has contributed to the Child Death Review program) – From FY 2020 forward, this fund will no longer be included in FHSD's budget and is therefore anticipated to phase out of the Title V application.

Form 2 also notes that expenditures from other federal funds administered through the various FHSD programs in FY 2020 totaled \$30,928,565. These other federal fund expenditures include programs such as WIC (\$22 million), Home Visiting (MIECHV) (\$2.5 million), Early Intervention (Part C) (\$2.2 million), Genetic Services (\$569,000), and at least 14 more federal programs.

Clients Served. Form 5a reports on the number of clients receiving direct or enabling services with Title V and state matching funds. The total served is 38,072 broken out as follows:

Pregnant Women: 902
Infants 1 < 21 Years of Age: 339
Children 1 through 21 Years of Age: 12,519
Including Children with Special Health Care Needs: 8,033
Others: 24,312

Form 5b estimates FHSD programs using all funding sources were able to reach: 99% of Pregnant Women; 99% of all Infants < 1 year of age; 43% of Children 1-21 years of age; 23% of Children with Special Health Needs (0-21 years of age); and 47% of Others.

Use of Title V Funds. To support the infrastructure needed to administer FHSD programs statewide in FY 2020, Title V funds were used for key staff positions (20.85 FTE out of a total of 272.0 FTE), including an epidemiologist, branch research statisticians, MCH and CSHN program managers, Title V CSHCN Director, nurses, nutritionist, audiologist, contract specialists, information specialist, and general office support staff. These positions are critical to securing, leveraging, and managing FHSD's statewide service system and its broad array of funding sources by addressing statewide surveillance needs; developing critical statewide partnerships; and improving quality to assure services are family centered, culturally competent, and community based.

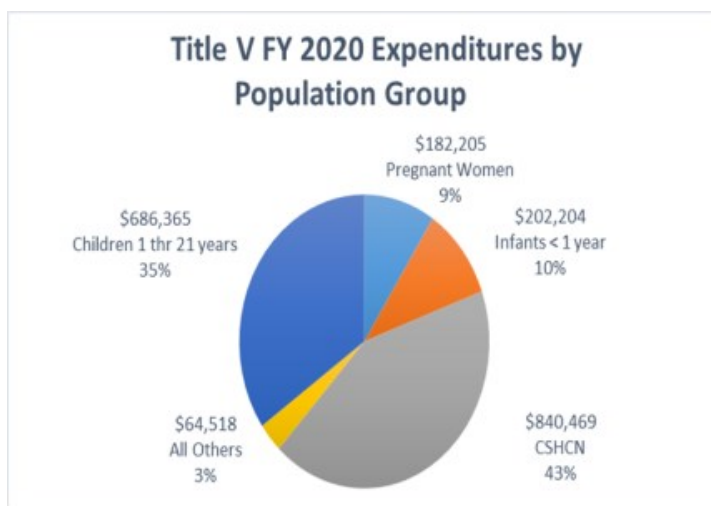
Legislative Requirements Met. The State maintains expenditure and budget documentation for all MCH Block Grant funding allocations for tracking and reporting. Consistent with the requirements in the Title V legislation, expenses are tracked through the state accounting system, *Datamart*, and carefully monitored by fiscal and program staff. The FHSD program undergoes an annual audit required for all state departments.

The Title V legislation also requires a minimum of 30% of block grant funds be used for preventive and primary care services for children and at least another 30% for services for CSHCN. No more than 10% of the grant may be used for administration. Form 2 reports that Hawaii met these requirements for FY 2020 expenditures. The table below outlines the FY 2020 budget and expenditures across these categories. Preventive/primary care for children was 33.3% of FY 2020 Title V expenditures, while CSHCN received 40.8% of Title V funds in the same year. Hawaii was able to keep administrative costs relatively low (3.9%) because DOH relinquishes all indirect costs for the Title V grant.

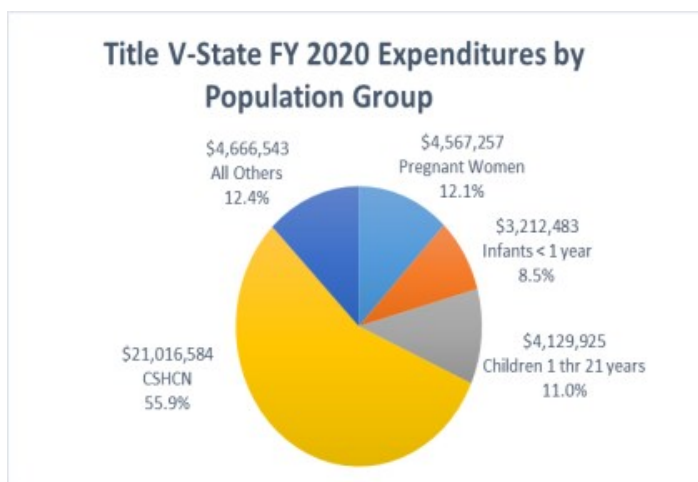
Category	FY 2020 Budgeted		FY 2020 Expended	
Preventive and Primary Care for Children	\$626,263	30.2%	\$686,365	33.3%
Children with Special Health Care Needs	\$816,576	39.3%	\$840,469	40.8%
Title V Administrative Costs	\$72,424	3.5%	\$79,665	3.9%

Further legislative requirements include Section 505(a)(4), which states that the State must maintain the level of funds being provided solely by the state's MCH programs at the level provided in fiscal year 1989 (\$11,910,549). With the exponential growth of FHSD since 1989, the FY 2020 state expenditure match of \$35.6 million far exceeds the match requirement.

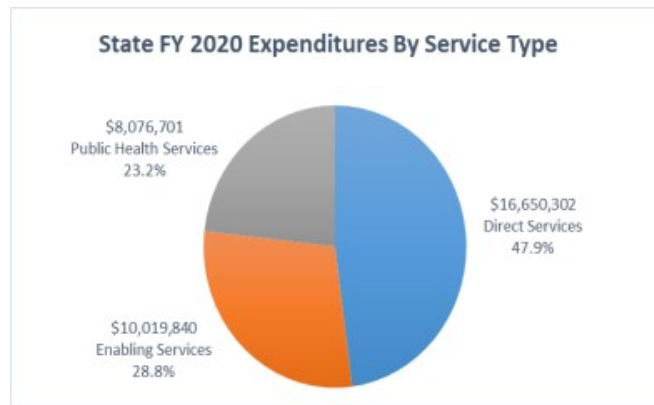
Expenditures by Population Group. The chart below shows how the FY 2020 \$2.0 million Title V funds were expended to serve the five Title V population groups. The amounts reflect expenditures for FHSD Title V funded personnel (20.85 FTE in 2020) who support FHSD programs across the state and \$10,000 for the state MCH hotline. No Title V funds were used for direct services. The breakouts confirm Hawaii expended over 43% for CSHCN; 35% for Children 1 through 21 Years; 10% for Infants < 1 year; 9% for Pregnant Women; and 3% for All Others.



The chart below shows how the FY 2020 \$37.6 million state matching funds were expended to serve the five Title V population groups as reported on Form 3a, IB, Non-Federal MCH Block Grant. The amounts reflect costs for both personnel and operating (including contracts for service delivery). Over half of FHSD's state funds were dedicated to serve CSHCN (55.9%). The remaining budget was divided by the last four population groups: All Others (general adult population/families), pregnant women, children, and infants.



The chart below illustrates how both Title V and state matching funds in FY 2020 were expended by type of service as reported on Form 3b, IIB, Non-Federal MCH Block Grant. The amounts reflect costs for both personnel and operating (including contracts for service delivery). Services for CSHCN made up about half of all FHSD Direct Service expenditures. Of the Non-Federal total expenditures, Direct Services made up 47.9% of all expenditures. The remaining state expenditures were divided between enabling (28.8%) and public health services (23.2%). Analysis of these expenditures helps confirm Hawaii clearly leveraged Title V funding to provide infrastructure support for its MCH programs.



Listed below are the FHSD program by Service Type. Programs often perform several types of services; however, this table reflects the primary function of each program. Note that the list below includes programs funded by the Title V-State partnership and other federal grants.

Service Type	Program
Direct	Family Planning Perinatal Support Services Early Intervention Primary Care Services for Uninsured Children and Youth with Special Health Needs*
Enabling	Early Intervention* Children and Youth with Special Health Needs* Hawaii Home Visiting Program and Network Breastfeeding Support WIC Services Parenting Support Program Sexual Violence Prevention Teen Pregnancy Prevention
Public Health Services and Systems	PRAMS Birth Defects Monitoring Newborn Hearing Screening Newborn Metabolic Screening Child, Maternal, Domestic Violence Fatality Review Early Childhood Comp Systems Child Abuse and Neglect Prevention Childhood Lead Poisoning Prevention Child Abuse and Neglect Prevention Adolescent Health Program Domestic Violence Prevention Oral Health Program Primary Care Office Office of Rural Health Critical Access and Small Rural Hospitals program

Significant Variations – Form 2 and Form 3 (Federal Fiscal Year 2020) – Expenditures

Form 2, Item 5. Other Funds. The amount budgeted in this category for FY 2020 was \$203,441, which is the legislative authorized ceiling for this appropriation account. The \$49,934 in expenditures represents the remaining balance in the now obsolete account. These funds represented an interdepartmental transfer from the Department of Human Services (DHS). FHSD will not report on this source of funds moving forward.

Form 2, Item 6. Program Income. In FY 2020, the budgeted amount for program income was \$13,584,510 but expenditures were only \$8,622,714. The reason for the difference is that the authorized budget ceilings for the Community Health Centers Special Fund, Early Intervention Special Fund, and Domestic Violence and Sexual

Assault Special Fund are higher than the revenues being deposited into these accounts. Annual expenditures are roughly aligned with the revenues being deposited and are not aligned with the authorized budget ceilings for these special fund accounts. The FY 2021 state legislature transferred more than \$10 million from FHSD special funds to replace state revenue shortfalls caused by the COVID-19 pandemic that will affect future reporting periods. Additionally, the legislative authorized ceiling will continue to differ from actual expenditures moving forward. Note that this disparity proportionally affects the budgeted vs. expended reporting on Form 2, Items 7 and 8, which both incorporate Program Income into their overall calculations.

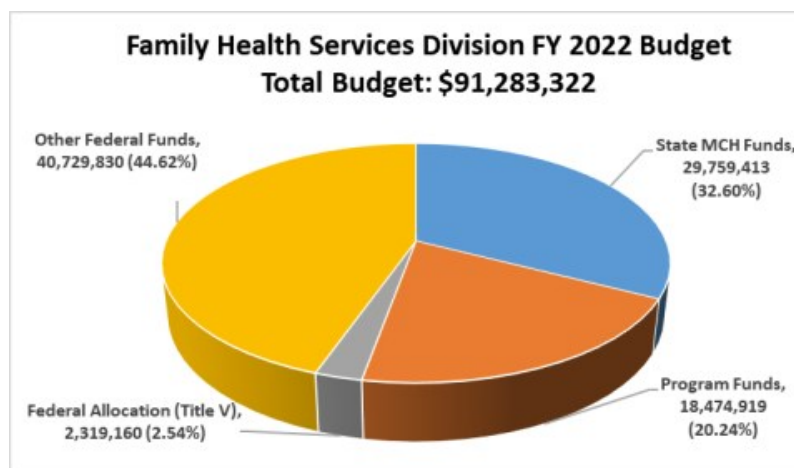
Form 2, Item 10. Other Federal Funds. The amount budgeted for this category in FY 2020 was \$45,765,848 but the amount expended was only \$30,928,565. The difference between budgeted and expended is primarily due to the Title V budget period not aligning with many of FHSD's federal grant budget periods. Therefore, only federal expenditures that fall during the Title V budget period will be reflected in the Title V application, whereas the \$47 million captures all annual federal funds budgeted. Note that a similar disparity exists between budgeted and expended for the State MCH Budgeted/Expenditure Grand Total as reported on Form 2, Item 11.

III.D.2. Budget

Every day, the Hawaii State Department of Health (DOH), Family Health Services Division (FHSD) works to improve the health of women, children, and families throughout the state. FHSD achieves this work through its division, branch, and District Health offices, which consists of 30 programs; nearly 150 service contracts; and, in Federal Fiscal Year (FY) 2022, a \$91.3 million total state MCH Budget funding 19.55 Title V positions out of a total of 277.0 FTE. The FY 2022 budget plan builds on the assessment of state MCH population needs and Title V program needs while maintaining a commitment to complying with the legislative financial requirements and block grant program regulations (i.e., 30% - 30% - 10% requirements).

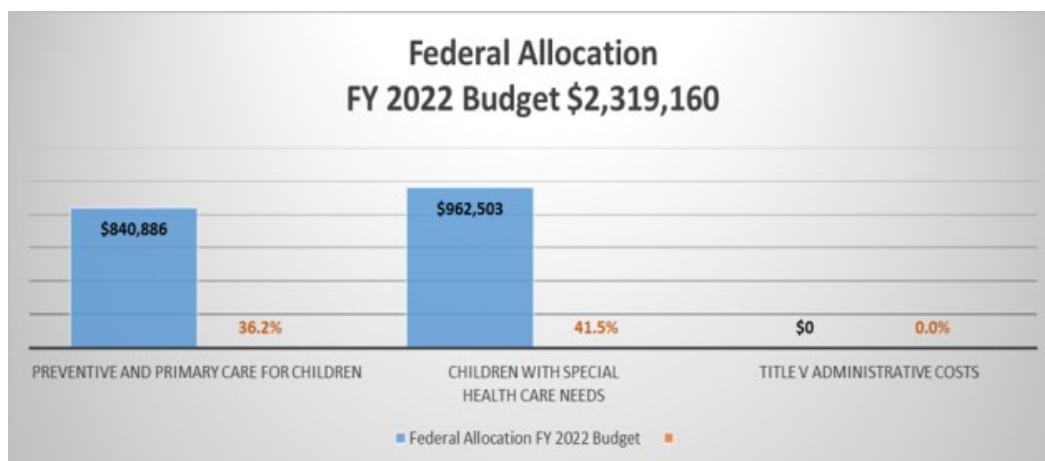
Budget Overview

The chart below provides an overview of FHSD's FY 2022 budget as reported on Form 2. The \$91.3 million FY 2022 budget is comprised of \$2,319,160 from Title V; a state match of nearly \$50 million (including Program Income of \$18.5 million), and Other Federal Funds totaling \$40.7 million.



Legislative Requirements Met. FHSD is committed to complying with the legislative financial requirements for Title V. The State will maintain expenditure and budget documentation for all MCH Block Grant funding allocations through the state accounting system, *Datamart*. FHSD will comply with the state annual audit. Additionally, the State will satisfy the required match, which includes a \$3 match in non-federal funds for every \$4 of federal MCH Block Grant funds expended [Section 503(a)] and the maintenance of effort from 1989 [Section 505(a)(4)].

FHSD is committed to continued compliance with the financial requirements that a minimum of 30% of Title V funds are utilized for preventive and primary care services for children; at least another 30% is utilized for services for CSHCN; and no more than 10% of the grant used for administration. For FY 2022, Hawaii is allocating \$840,886 (36.2%) for Preventive and Primary Care for Children; \$962,503 (41.5%) for CSHCN; and no funds will be budgeted for Title V Administrative Costs as reported on Form 2, Lines 1. A, B, and C.



Federal Funds. The FY 2022 Other Federal Funds budgeted includes 20 federal grants totaling \$40.7 million (excluding Title V). The Title V allocation is \$2.3 million, which is roughly 5.7% of all FHSD federal fund appropriations and 2.5% of the overall FHSD total budget.

In FY 2022, the overall FHSD federal fund budget increased by \$3.5 million (+8.6%) from FY 2021 due to the CARES Act and American Rescue Plan Act (ARPA) fund appropriations for several programs including the following:

- Small Rural Hospital Improvement Grant, Coronavirus State Hospital Improvement Program \$843,170
- Sexual Violence Primary Prevention and Education supplemental award \$15,307
- AMCHP CARES Act Project \$275,000
- WIC Special Supplemental Award \$2,287,072
- Community-Based Child Abuse Prevention supplemental award \$1,000,179
- MIECHV ARPA funding for Home Visiting \$334,763

As in years past, FHSD relies heavily on federal funding (47% of total budget). Most grants are utilized to fund positions that manage and administer federally funded programs. In FY 2021, consistent with recent trends, most of the federal grants' funding remained level, which creates budget challenges as program costs increase. Operating and personnel costs for federal grants like Title V, Pregnancy Risk Assessment Monitoring System (PRAMS), and Primary Care Office (PCO) may soon exceed award amounts because of rising costs. For example, consistent increases in collective bargaining agreements for public employees has contributed to steady increases in salaries and fringe benefits. The FY 2021 indirect cost rate (percentage charged of total salary and fringe) was 17.3% and the fringe benefit rate was set at 52.83%. For programs that rely on grant funding for positions, this can be a substantial expense. As a means of offsetting fixed costs, in some cases, FHSD requested and received a department waiver of indirect costs. Title V is one of a few grants that the department has allowed an annual indirect cost waiver that ensures maximum use of the grant dollars for personnel and operating expenses. FHSD also leverages its funding from other grants to support programs and continues to seek state funds through the budget process. As a way of managing costs, programs have postponed filling positions when vacated through retirement or attrition. Programs have also redescribed vacant positions from high-salary medical professional positions (e.g., nurses) to public health supervisor-type positions. State and federal budget funding cuts coupled with rising operating costs led FHSD personnel numbers to shrink from 337.5 FTE in FY 2018 to a projection of 277.0 FTE or less for FY 2022.

Potential COVID Impacts: Finding creative ways to maximize and leverage FHSD federal and state resources may remain a challenge in FY 2022. While still too early to determine the extent of state and possibly federal fund

restrictions/reductions, the COVID-19 pandemic crippled Hawaii's economy for more than 12 months. The economic fallout has been enormous in Hawaii as the state's tourism-based economy came to a complete standstill in March 2020. Although, unemployment has improved with the opening of the economy, the state unemployment rate remains the highest in the nation. The economic downturn will affect the State's tax revenue, which will in turn impact the State's budget moving forward. DOH was not allowed to request additional state funds in the 2021 legislative session; therefore, state funding is expected to be flat in FY 2022. Restrictions and funding cuts are still possible despite a recent rebound in tourism.

State Funds: The FY 2022 state funds budget total is \$29.8 million. Additional state funds generated from Program Income is budgeted at \$18.5 million in FY 2022, according to SFY 2021 legislative budget worksheets. Note that the economic effects of the pandemic are anticipated to linger to some degree through FY 2022. Budgetary restrictions are anticipated but specifics will not be known until the SFY 2022.

Leveraging Resources: FHSD continues to leverage resources through national, state, and community partnerships. This is particularly true with the use of Title V funding that supports staffing that provides public health infrastructure services for FHSD's programs. The 19.55 Title V funded FTE positions are critical to securing, leveraging, and managing a broad array of funding sources that address statewide surveillance needs; develop critical statewide partnerships, and improve quality to assure services are family centered, culturally competent, and community based.

Although, WIC does not receive Title V or state funds, the program benefits from FHSD administrative support, epidemiology assistance, and technical assistance through collaboration with other FHSD programs. WIC also contributes significantly to Title V priorities related to pregnant women, infants and young children and coordinates with other FHSD programs serving the same populations.

By leveraging the MCH Block grant funds through Title V funded personnel, FHSD will continue to serve and improve the health and well-being of Hawaii's mothers, children (including children with special needs), and their families. The Title V program efforts and outcomes discussed in the State Action Plan and other sections of this application could not have been achieved without federal MCH Block Grant funding support.

Because DOH is the only public health agency in the state, the absence of local, city, and county health departments in Hawaii requires a disproportionate amount of infrastructure personnel within FHSD to strategically plan and administer resources statewide. The Title V MCH Block Grant provides a critical source of funding for FHSD infrastructure positions. In FY 2020, for example, Title V funded positions provided critical leadership direction and data support to manage state funding for the Child Death Review, Maternal Mortality Review, and also the continuation of the Lead Poisoning Screening and Prevention program, which is currently applying for a renewed funding project from the CDC.

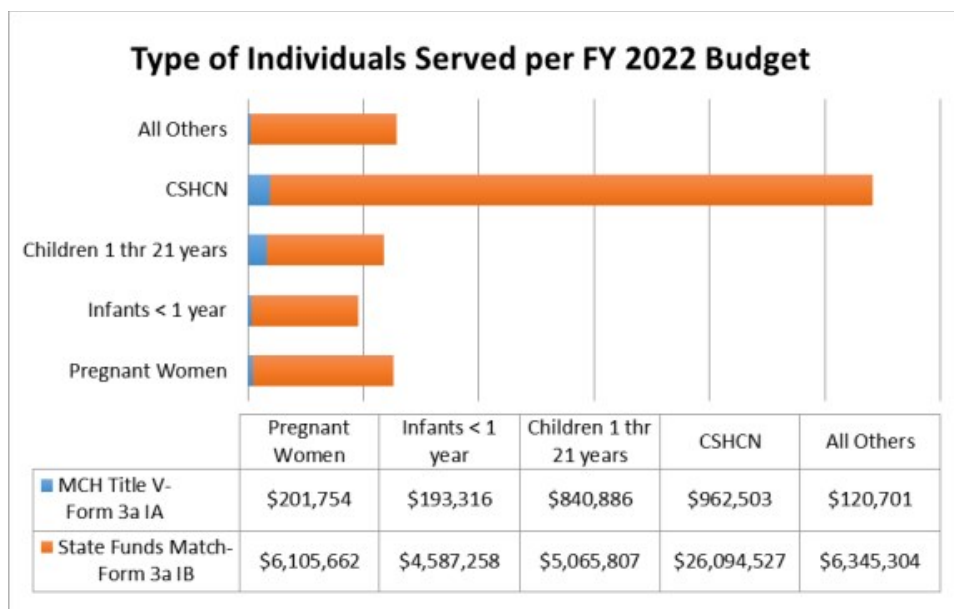
Another example of leveraging Title V funding is found in the distribution of the funding to support key positions within FHSD. The CSHNB Chief, also a pediatric M.D., is 75% funded with Title V and 25% Part C funding. She also supervises Hawaii's Part C Early Intervention Services program as part of CSHNB. A portion of both grants are used to support this critical management and medical professional position for FHSD.

The program and staff support for the Title V priorities reflect the diversity in the FHSD budget and the importance of leveraging program funding to support the priorities. FHSD uses both state and federal funding to support the work on the FY 2020 priority issues.

Title V Priority	Program Lead Funding	Key FHSD Partnerships
Women's Wellness Visits	Women's Health Section (Title V/State Family Planning Program)	Title V – Data/Epi Support Family Planning State Program
Breastfeeding	WIC Services (DOA)	Title V – Data/Epi Support Early Childhood Comp Systems Perinatal Support program (State)
Safe Sleep	PRAMS (CDC)	Title V – Data/Epi Support Early Childhood Comp Systems Child Death Review (State)
Developmental Screening	Early Childhood Comp Systems	Title V – Data/Epi Support Maui DHO (State) EIS (Part C/State) MIECHV Hiilei Developmental Screening (State)
Children's Oral Health	State Oral Health Program	Title V – Data/Epi Support DOH Developmental Disabilities Dental Program (State)
Child Abuse and Neglect	Community based Child Abuse Prevention Program (ACF)	Title V – Data/Epi Support MIECHV Preventive Health and Health Services Block Grant (CDC) Rape Prevention and Education (CDC)
Adolescent Wellness Visits	Adolescent Health (Title V)	Title V – Data/Epi Support Personal Responsibility Education Program
Transition to Adult care	CSHN Program (State)	Title V – Data/Epi Support
Telehealth	Genetics	Title V – Data/Epi Support Rural Health

Diverse funding sources and staffing will also be used to support four new state priorities emerging from the pandemic. The 5-year plan narratives describe the program leads for each existing and new priority and their primary sources of funding. Partnerships within FHSD, DOH, and the community are also described in the performance measure narratives as vital resources to assure program progress.

Form 3a, Budget and Expenditure Details by Types of Individuals Served. FY 2022 application budgeted demonstrates the federal and non-federal FY 2022 application budget. The chart below shows the state and federal breakout of planned resource allocation for each of the five population health domains. The 2022 Title V Federal Allocation budget of approximately \$2.3 million and a State Match of \$48.1 million create a Federal-State Title V Partnership budget of approximately \$50.5 million. The combined resources form the funding base for strategic collaborations with community providers and partners statewide. Annually, FHSD administers approximately 150 contracts with community organizations that serve Hawaii's MCH population. These vendors include Federally Qualified Health Centers (FQHC), local hospitals, and private and nonprofit providers in urban and rural communities throughout the state. The funds play a key role in building statewide capacity to assure the availability of services for all of Hawaii's families.



FHSD will continue efforts to ensure statewide infrastructure for needs assessment, surveillance, planning, evaluation, systems/policy development, training, and technical assistance to assure quality of care into the FY 2022 budget year.

Significant Variations – Form 2 and Form 3 (Fiscal Year 2021) – Budget

Form 2, Item 3. State MCH Funds. The budgeted amount \$31,499,929 was based on the SFY 20 Hawaii legislative authorized budget ceiling for overall operating and personnel costs. The authorized budget ceiling is normally higher than the actual expenditures, which is often affected by position vacancies and changes or reduction in contractual execution and performance.

Form 2, Item 5. Other Funds. The category “Other Funds” decreased 100% from \$203,441 in the FY 2020 application to \$0 in the FY 2021 application. The \$49,934 in FY 2020 Annual Report Expended was the remaining balance from this fund. From FY 2021 moving forward, this category will phase out of the FHSD budget/expenditure Title V narrative.

Form 2, Item 6. Program Income. The amount budgeted on the FY 2020 application was \$13,584,510 but expenditures were only \$8,622,714. The reason for the difference is that the authorized budget ceilings for the Community Health Centers Special Fund, Early Intervention Special Fund, and Domestic Violence and Sexual Assault Special Fund are much higher than the revenues being deposited into these accounts. Annual expenditures are roughly aligned with the revenues being deposited and are not aligned with the authorized budget ceilings for these special fund accounts. The legislative authorized ceiling for overall Program Income will continue to differ from actual expenditures moving forward.

Form 2, Item 7. Total State Match. Similar to comments regarding Program Income budget and expenditures, the Total State Match budgeted includes the legislative budget ceiling for general and special funds. Actual expenditures are usually lower due to a more accurate reflection of expenditures based on program revenue with vacancy savings and contract performances taken into account.

Form 3a, IB. Federal State MCHB Block Grant Partnership Total. The amount budgeted in FY 2022 is \$12,924,926

more than was expended in FY 2020. The variance can be attributed to the change in methodology in calculating Program Income (see Form 2, item 6), which contributes to this category. The budgeted number represents the legislative authorized ceiling that will continue to be substantially greater than actual expenditures.

Form 3b, IIB. Non-Federal Total. The FY 2022 budget for Non-Federal MCH Block Grant direct services is nearly \$9,346,991 more than was expended in FY 2020. The increase can primarily be attributed to the change in methodology of calculating program income allocated to direct services. The budget reflects the legislative authorized ceiling whereas expenditures are actual.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Hawaii

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

In Hawaii, the Family Health Services Division (FHSD) serves as state Title V MCH agency. FHSD is committed to improving the health of women, infants, children, including those with special healthcare needs, and families. FHSD works to promote health and well-being using a life course and multi-generational approach to address social determinants of health and health equity.

Because the Department of Health is the only public health agency in the state, FHSD is the only MCH agency in the state and provides all levels of service delivery: direct, enabling, and infrastructure building for all counties. Service contracts for all county/community providers are executed through FHSD central program offices located on Oahu in consultation/coordination with county staff. FHSD programs work to ensure statewide services delivery, as well as infrastructure for data collection, needs assessment, surveillance, planning and evaluation, systems and policy development, and the provision of workforce training and technical assistance to assure quality of care.

FHSD is comprised of three branches—Maternal and Child Health; Children with Special Health Needs; and Women, Infants, and Children (WIC) Services—and several offices and programs at the division level.

At the division-level, FHSD oversees the following programs:

- Title V MCH Block Grant Program
- Early Childhood Comprehensive Systems (ECCS)
- Oral Health Program
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Office of Primary Care and Rural Health including the Primary Care Office (PCO), State Office of Rural Health, Medicaid Rural Hospital Flexibility Program, and mall Rural Hospital Improvement Program.

The **Maternal and Child Health Branch (MCHB)** administers a statewide system of services to reduce health disparities for women, children, and families of Hawaii. MCHB programs provide core public health services that establish and maintain public and private partnerships to share information; support program planning; and collaborate on/promote policies to improve outcomes for women, children, and families. Services include training and public awareness to high-risk women, adolescents, and other disparate populations on family planning, perinatal, and interconception care; child and youth wellness; prevention of child abuse and neglect; sexual assault prevention; domestic violence prevention; and home visiting services and family supports. Some of the programs include: The Parent Line, Child Death Review, Maternal Mortality Review, Domestic Violence Fatality Review, and over 35 community provider contracts for women's health and family planning services.

The **Children with Special Health Needs Branch (CSHNB)** works to improve access for children and youth with special healthcare needs to a coordinated system of family-centered healthcare services and improve their outcomes. This is addressed through systems development, assessment, assurance, education, collaborative partnerships, and supporting families to meet their health and developmental needs. Programs include:

- Children and Youth with Special Health Needs Section: Children with Special Health Needs, Early Childhood, Hi'iilei Developmental Screening, and Childhood Lead Poisoning Prevention.
- Genomics Section: Genetics, Birth Defects, Newborn Hearing Screening, and Newborn Metabolic Screening.
- Early Intervention Section (EIS): Mandated early intervention services provided through three state-operated programs and 15 purchase of service programs. The Hawaii Early Intervention Coordinating Council, established under HRS §321-353, advises and assists EIS in the performance of its responsibilities under Part C of the Individuals with Disabilities Education Act (IDEA).

The **Women, Infants, and Children (WIC)** Special Supplemental Nutrition Program is a \$29 million United States Department of Agriculture (USDA) Food and Nutrition Service (FNS) federally funded, short-term intervention program. USDA FNS provides federal grants to states for supplemental foods, healthcare referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women and for infants and children up to age 5 who are found to be at nutritional risk. The WIC Branch of FHSD administers the USDA FNS WIC program for the State of Hawaii.

COVID Impacts on Staff: The pandemic resulted in a year of unrelenting and unprecedented change in all aspects of work and personal life. We continue to be challenged to find time to pause, assess, acknowledge current conditions, and respond to the needs of both staff and populations served. Given the consequences of the pandemic, this report reflects changes, delays, and innovations that occurred over the past year.

FHSD Vision/Mission: In FY 2020, FHSD intended to update its vision/mission statement and organizational documents in conjunction with the updating of the DOH strategic plan. In October 2020, consultation was conducted with Karen Treiweiller, MCH consultant and former Colorado Title V director, to assist with this effort. However, both the department and FHSD plans were delayed due to COVID. FHSD hopes to proceed with updates in FY 2022.

Title V Role: To meet the objectives in the Title V 5-year plan, FHSD program leadership roles are varied including:

- Provide or assure services that address system gaps or critical needs
- Convene of stakeholders to address priority issues
- Fund for personnel, services, and activities
- Partner in collaboratives and coalitions
- Provide or broker technical assistance and workforce training
- Secure and share data to help inform planning and policy
- Promote innovative and evidence- based or-informed practices
- Support efforts to develop coordinated, comprehensive, and family-centered systems of care, especially for children and youth with special healthcare needs

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

With 283 employees and an annual budget of \$95 million, the Family Health Services Division (FHSD) is the second largest division in the Hawaii State Department of Health (DOH). FHSD staff have varied professional experience and training. Very few FHSD program staff have formal training in public health. Most have program management experience or subject matter knowledge in their respective areas.

Workforce development opportunities for staff are funded by or through federal grants that support participation in national conferences, access to subject matter experts, research, technical assistance (TA), and state peer networking. State-funded staff generally have less access to these resources.

COVID Impacts on Program Staff: The pandemic resulted in a year of unrelenting and unprecedented change in all aspects of work and personal life. It was challenging to find time to pause, assess, acknowledge current conditions, and respond to the needs of both staff, community partners, and the populations served.

While the pandemic focused public attention on the importance of public health, it also brought closer scrutiny of the department's work by policymakers and the public, increased criticism at times, and demands/requests for greater responsiveness. There was little recognition of limited department staffing, funding, and cumbersome personnel/procurement restrictions.

Over the course of 2020, new policies and procedures were drafted and implemented with short notice. Responding to contractor and community requests/needs required quick action from Title V programs. The high level of uncertainty and resulting stress for management and staff cannot be understated. Moments of fear, anxiety, and panic were commonplace. Staff showed high levels of flexibility, adaptability, and resiliency to continue program work. Despite the many challenges experienced as a result of the pandemic, nearly half of FHSD program managers reported that the pandemic strengthened program operations and partnerships.

In a 2021 survey of Title V program managers, the top three program concerns were:

- Strengthening health equity efforts (73.9%)
- Staff capacity to address emerging needs/changes (73.9%)
- Staff morale/well-being (65.2%)

Survey results will be reviewed to inform design of an employee survey as well as workforce training and employee engagement activities.

Trauma Informed Care Training: Title V Violence Prevention and Early Childhood Systems programs, as part of continued Trauma Informed Care (TIC) training, conducted a FHSD staff survey in November 2020 to gauge interest in TIC topics to design a webinar to meet staff needs, particularly those working directly with families/youth. Staff response was high with most reporting that the information would be useful both professionally in their program work with families and partners, as well as personally. A webinar was held in February 2021 on "Trauma Informed Care Training," focusing on understanding trauma informed care, the effects of cultural and historical trauma, approaches to build healthy and resilient communities, and techniques to model patience and care to families. Approximately 50 participants attended.

2020 Needs Assessment Work delayed: As part of the 2020 needs assessment Hawaii reviewed the results from the DOH national Public Health Workforce survey (PH WINS). The 2017 survey results, conducted nationally by the Association of State and Territorial Health Officials (ASTHO) and the de Beaumont Foundation, were released in

2019. The survey helps public health agencies understand workforce strengths, gaps, and opportunities to improve skills, training, and employee engagement. Overall, recommendations for DOH improvement were:

- Succession-planning
- Assessment and investment in training
- Workplace policies/practices that support employee engagement and organizational satisfaction

The de Beaumont Foundation conducted a separate analysis of the responses for FHSD since the division represented 10% of total department responses. Although the numbers were too small to be conclusive, the results largely reflected those of DOH.

FHSD worked with the DOH Administrative Deputy to present the survey results to the DOH management team. The PH WINS findings were to be used to create a departmental initiative addressing workforce development needs including promoting the 2020 PH WINS with employees. However, this effort was delayed due to other department priorities including the DOH response to the COVID pandemic. The 2020 PH WINS survey was also postponed due to COVID.

Plans for Employee Survey: FHSD planned to field an employee survey to capture staff demographics and concerns to assess division/program diversity, inform succession, and workforce training planning.

Title V Public Health Capacity: FHSD uses Title V as an opportunity to build public health capacity for program staff. From 2018-2020, Hawaii partnered with University of Hawaii Office of Public Health Studies (OPHS) faculty to develop logic models for each of the Title V priorities to assess program progress, achievement of short- and long-term outcomes, identification of barriers/challenges, and ensure the alignment of strategies with Title V measures. This followed a recommendation from a 2018 AMCHP skills-building session.

In FY 2021, SSDI funds were used to continue TA for staff by Nancy Partika. Ms. Partika served as faculty for the former MCH Certificate program at OPHS. She also has extensive public health experience working for DOH as well as leading community nonprofits like Healthy Mothers, Healthy Babies. Her TA supported building staff public health knowledge and helped staff assess and respond to the challenges posed by the COVID pandemic. Ms. Partika also assisted staff with the review of research by the MCH Evidence Center (EC) to support strategy selection and promote health equity. She developed a resource list of best practices for staff to advance health equity.

National Resources: Title V continues to use national MCH and AMCHP professional development resources including the MCH Workforce Development Center (WDC). Staff participated in two WDC cohorts to date and routinely participate in the strategic skills institutes, including the virtual sessions held in 2020.

Hawaii continues to use national TA from the MCH Evidence Center, AMCHP webinars, and MCH Bureau Learning labs to inform Title V efforts, especially for the 2020 needs assessment. These TA opportunities help develop staff capacity and provide an opportunity to share Hawaii's issues with other states and national centers.

Hawaii Public Health Training Hui: Another workforce development effort supported by FHSD is the Hawaii Public Health Training Hui (HPHTH) steering committee. The HPHTH is a group of individuals and organizations established to provide statewide leadership, coordination, and collaboration to meet identified common public health training and TA needs. FHSD's Rural Health coordinator serves on the HPHTH steering committee that provides general oversight and direction for the annual training series. Training topics are based on surveys disseminated online to employees in both the public and private sectors and guidance from the Western Region Public Health Training Center, which funds the Hui. Training sessions are recorded and posted on the HPHTH website

Trainings: FHSD programs also support training for the MCH workforce statewide. Several federal grants include workforce development as a key strategy/activity. In 2020, many of these events were switched from in-person to virtual including:

- Maternal Infant Early Childhood Home Visiting grant supports monthly training for the Hawaii Home Visiting Network.
- Early Childhood Comprehensive Systems (ECCS) grant supports training for providers on developmental screening tools and protocols and other infant/toddler health and safety conferences.
- Hawaii Medicare Rural Hospital Flexibility Program grant is used to conduct training on healthcare quality improvement for healthcare professionals and operational and financial performance improvement for Critical Access Hospitals.
- The State Office of Rural Health sponsors numerous training projects including the annual Healthcare Workforce Summit and telehealth training through Project ECHO.
- A consortium of Title V programs support the Parent Leadership Training Institute.

In response to community concerns regarding family violence during the pandemic, the Title V violence prevention programs hosted a series of virtual webinars on domestic violence that drew a record 3,000 participants.

Programs also conduct presentations about health topics and Title V services. Many of these trainings were already conducted via webinars and include:

- Genetics offers webinars on current issues in genetics to providers.
- The Child Abuse and Neglect (CAN) Prevention program conducts presentations on Adverse Childhood Experiences, Trauma-Informed Care, and Protective Factors to prevent CAN.
- Adolescent Health partners with community health workers and youth service providers to promote healthy youth development and adolescent wellness visits.
- Normally, WIC staff conduct breastfeeding training seminars to community providers; however, none were conducted during the pandemic.

Programs may also sponsor annual conferences for providers to receive updates on research, best practices, and data. Examples include:

- Annual DOH Rape Prevention and Education Sexual Violence Prevention Meeting
- Hawaii State Rural Health Association Annual Conference
- Early Intervention Stakeholder Conference
- Hawaii Home Visiting providers meetings
- Hawaii Mortality Review Trainings/Summit

Due to the pandemic, all meetings were switched from in-person to virtual platforms.

III.E.2.b.ii. Family Partnership

Hawaii remains committed to increase engagement of families across Title V programs. In this complex and evolving healthcare environment, FHSD recognizes the importance of parental/consumer involvement and hopes to build Title V staff and program capacity in this area.

Building Title V Capacity: This report highlights efforts to systematically build the Title V agency capacity for family partnership/engagement. Several FHSD programs have a strong family engagement (FE) component to their work, especially CSHN programs and grant funded programs with a FE requirement. However, the goal for Title V is to build FE capacity across all programs. This effort began in 2018 by convening an initial Title V FE workgroup to identify potential strategies to assess and support integration of families into Title V programs. Participants in the group included several Title V staff (CSHN, Early Childhood programs, and neighbor island nurses) as well as two key partners:

- Family-to-Family Information Center (F2FIC) Director and
- Hawaii Children's Action Network (HCAN), a nonprofit advocacy organization for children and families.

Ideas discussed by the workgroup included:

- Development of an FE policy as part of the updating of FHSD vision/mission statements
- Review of national FE guidance/resources
- Assessment/documentation of FHSD staff FE knowledge, current (best) practices, and program barriers/supports needed to implement FE
- Compilation of FHSD FE opportunities and development of materials to promote engagement with families
- Conduct FE training for programs featuring FHSD best practices, state, and national resources
- Support/fund evidence-based family leadership training programs
- Support family attendees to local and national conferences including AMCHP
- Conduct environmental scan of state family support/leadership organizations
- Partner with F2FIC to identify state/county level opportunities for family participation in boards and commissions
- Work with family leaders to explore the development of a statewide family leadership network

Over 2018-2019, the workgroup conducted two FE surveys of FHSD programs. The first survey was designed to:

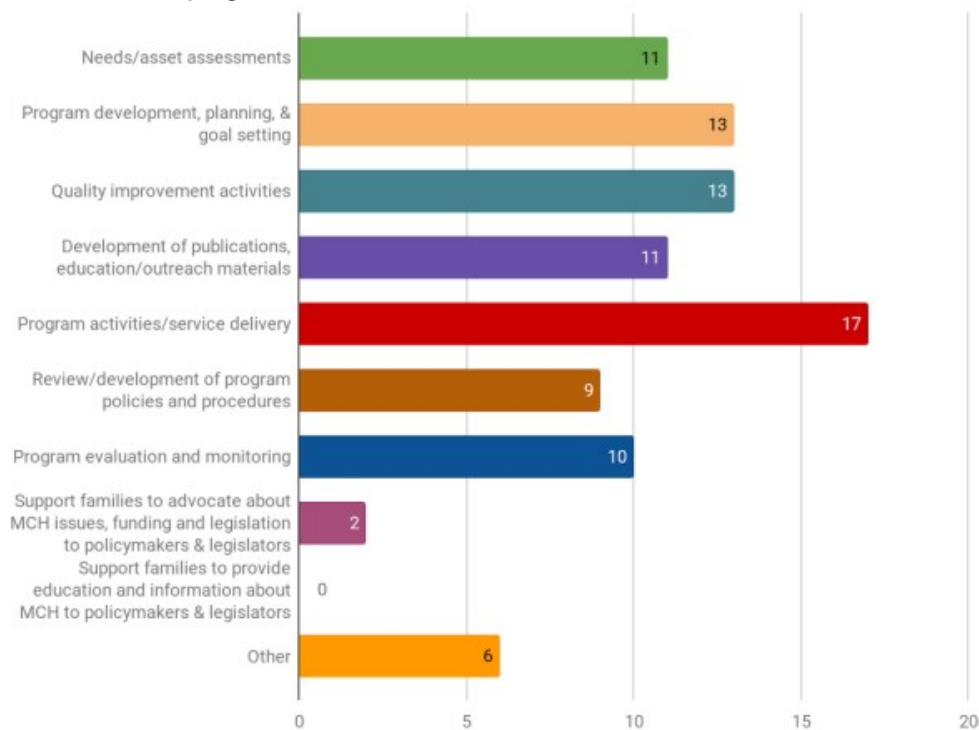
- Help increase awareness and promote family engagement
- Assess knowledge of the importance and purpose of family engagement
- Identify programs with current FE practices
- Collect input on how family engagement practices could be expanded.

FHSD reported the findings to staff through a two-page infographic factsheet, which can be found in the supporting documents.

The second survey captured more detailed information on FHSD FE opportunities for families and to identify supports needed to encourage more FE (i.e., recruitment of families, guidance, and actual compensation for family sharing of life experience/expertise). The results provide the latest systematic assessment of FHSD FE opportunities and will be updated in FY 2022.

FHSD programs were asked about the types of input collected or information provided for families, caregivers, and youth. The three most collected type of input or information were to inform families about program activities/service delivery (17); program development, planning, and goal setting (13); and quality improvement activities (13). The

areas programs are least likely to collect family information include policy development and supporting families to advocate for MCH programs and concerns.



FHSD programs were asked about opportunities for parent, family, or the community to volunteer. The areas of opportunities identified were: 1) advisory committees or task forces, 2) program outreach efforts, 3) family surveys, 4) family events, and 5) participation in program activities with staff.

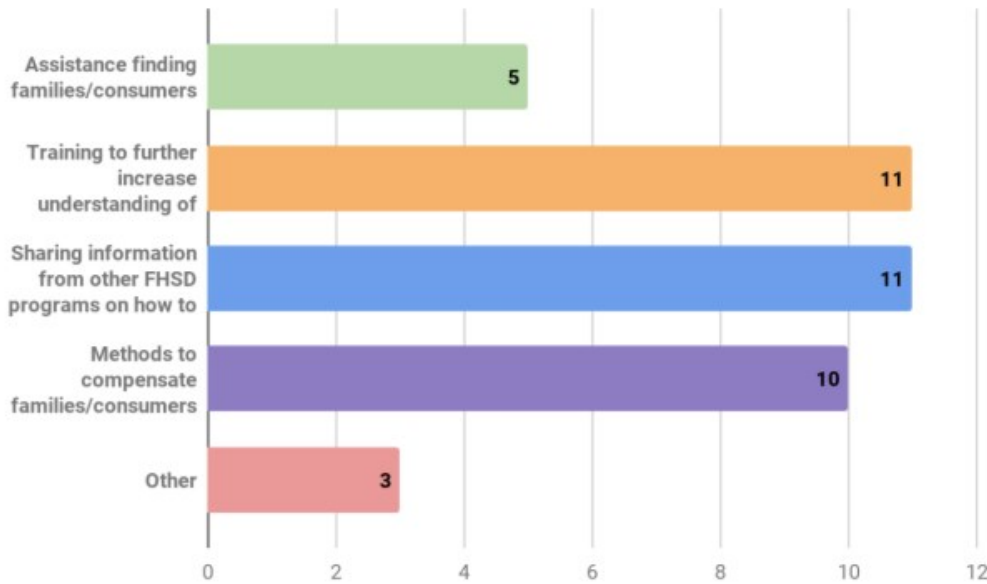
Eight advisory committees or task forces were identified as needing family volunteers, which includes the Violence Prevention program, Early Intervention Coordinating Council, Hawaii Children's Trust Fund Coalition, Newborn Hearing Program, Early Intervention program, Parent Leadership Training Institute (PLTI), Deaf and Blind Taskforce, and several service contracts that require community/client input for quality improvement.

While there are no paid family representative positions in FHSD, the WIC program does employ mothers part-time for its breastfeeding peer counseling program.

In 2019, five programs planned to conduct family surveys including the Title V needs assessment, WIC, Early Intervention, and Title V Transition to Adult Care workgroup. For family events, six programs identified annual community/family events, the month held, and the number of volunteers needed. Only two programs responded as having opportunities to participate in ongoing program activities with staff: the Domestic Violence Prevention program's Na Leo Kane ("the Voice of Men") initiative and Newborn Hearing Screening Program. Several programs reported FE needs sporadically as programs develop educational materials and messaging campaigns.

In the final portion of the survey, FHSD staff were asked what type of assistance is needed to help increase family engagement activities within their programs. The top three types of assistance needed were:

- Sharing information from other FHSD programs on engaging families (11)
- Training in further increasing the understanding of family engagement (11)
- Methods to compensate families/consumers for their time (10)



For those who selected assistance in methods of compensation, the three major types of compensation requested were gift cards/stipends, childcare, and travel vouchers/compensation.

The FHSD FE workgroup intended to do more follow-up work with the FHSD survey findings in FY 2019 but was challenged to reconvene. In FY 2020, the FE workgroup met again in spring; however, follow-up activities were largely put on hold due to COVID. The workgroup did continue to assure funding for the evidence-based Parent Leadership Training Institute (PLTI) program. Funds were leveraged across four federal grants and state funds.

AMCHP: FHSD also sponsored two parent professionals and a PLTI trainer to attend the 2019 AMCHP conference (the last in-person conference). A pre-conference orientation and networking meeting was held. Arrangements were made to assure ongoing support during the conference for the parent team and a debriefing session was conducted following the conference. The parents found the conference a rewarding experience and shared information from the conference sessions for use by FHSD programs. They also made suggestions to improve future FHSD AMCHP conference sponsorship efforts, including more preparation for parents, suggestions for selection criteria of family participants, and revisions to the FHSD orientation materials. The FHSD program descriptions and organizational charts in the supporting documents are a result of the parent team feedback.

Partnering with the MCH Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program, a young adult with special healthcare needs and her mother also attended the 2019 AMCHP conference. After the conference, the mother-daughter team served as one of the families that provided the Title V CSHN with important input on transition to adult healthcare policy statement and education/messaging materials. MCH LEND normally supports family participants to attend AMCHP when candidates are available. All conference support/orientation is provided by the LEND program staff who also attended AMCHP.

Parent Leadership Training Institute (PLTI)

As noted, FHSD programs continued to provide technical assistance and financial support to PLTI Hawaii, an evidence-based parent leadership curriculum administered by HCAN. FHSD also serves on the PLTI advisory board.

The PLTI curriculum consists of a 20-week training on leadership and civic engagement. All participants are required to plan, implement, and evaluate a community project that aims to improve child and family outcomes. A graduation ceremony is held where new parent leaders present their community projects. Members from the FHSD FE committee periodically participate in PLTI sessions, including presentations on community projects and graduation ceremonies. Information about PLTI Hawaii is available on the website <http://www.hawaii-can.org/plti>.

Pivoting to Virtual Sessions: In 2020-2021, PLTI sessions switched from in-person to virtual with two remote cohorts. The program had 22 participants from across the state. The biggest benefit to the virtual sessions was the ability to have participants from every island in the cohorts. Overall, there was not an increase in participation, but the geographical diversity of the participants enriched the interactions/experiences.

Surprisingly, the remote sessions did not adversely affect the ability of participants to develop deep personal connections as reported by previous in-person cohorts. The two virtual cohorts were able to network and bond as reflected in the participant evaluations (and the heartfelt sharing at the cohort graduations). The primary challenge for participants was learning the new videoconferencing program (Zoom) and all its features. Some participants also experienced difficulty with broadband connections.

Depending on COVID restrictions, HCAN plans to return to an in-person cohort for Maui in 2021-2022 with an additional remote cohorts to expand PLTI to Hawaii and Kauai counties.

PLTI Diversity: The diversity of PLTI participants is a primary focus of HCAN's recruitment efforts to assure inclusion of the states varied ethnic groups, parents with special needs children, and income levels. PLTI participants to date have included 28% Native Hawaiian; 41% Pacific Islander/Asian; and 56% have a family income of less than \$60,000. Over the past year, PLTI included discussions about race/structural racism into the curriculum given the global protests for racial justice. FHSD is supporting HCAN to modify the evidence-based PLTI curriculum to reflect Hawaii's unique cultural composition and history without loss of fidelity to the original model.

First-to-Work: HCAN, DOH Public Health Nursing, and the FHSD Early Childhood Coordinator are partnering with the Department of Human Services First-to-Work (FTW) entitlement program to offer a modified PLTI civic engagement training to FTW families, many of whom are young, single mothers seeking a path out of poverty. Plans are to offer a pilot program in early 2022 with a comprehensive evaluation.

Mini-grants: In 2020, FHSD was able to provide additional PLTI funding to create a mini-grant program to support participants community projects. Eight grants ranging from \$150-\$500 were awarded. The grantmaking process provided participants with experience developing and presenting funding proposals and helped increase parental empowerment and efficacy. Funded projects included the purchase of supplies to improve an outdoor space at a childcare program (to operate under COVID safety guidelines); purchase of a Zoom license to host weekly support groups meetings for parents of children with mental health issues; and costs to establish a website to encourage women to run for public office.

PLTI Alumni: The more than 80 PLTI Hawaii alumni continue to remain active and serve as mentors for new cohorts. The alumni group convenes twice a year and communicates via social media through Facebook pages/groups and Twitter. In 2020-2021, PLTI alumni used their acquired knowledge/skills to join two state Commissions: the Fatherhood Commission and the Developmental Disability Council. PLTI graduates were also active in the 2020 and 2021 legislative sessions, providing testimony on legislative bills impacting families. In 2021, a PLTI family will be featured in a State Oral Health Coalition PSA video to promote oral health check-ups for children. PLTI graduates have also been integrated into FHSD media campaigns by testing/evaluating messages, including the promotion of child wellness visits/immunizations for young children.

Leveraging Funding Opportunity: In FY 2021, FHSD used the new Early Childhood Comprehensive Systems Health Integration Prenatal-to-Three Program (ECCS HIPP) funding opportunity to advance FE efforts for FHSD. The ECCS HIPP grant has a strong commitment to the development of family leadership and engagement. As part of Hawaii's application, an environmental scan was conducted to identify some of the key family organizations in the state that could partner on developing a statewide resource for families with young children.

Environmental Scan: The landscape of state-level parent/family leadership organizations includes these government-related organizations:

- *The Community Children's Council (CCC) Office* is a state agency that came out of a class-action lawsuit against the state on behalf of children with special needs who also had mental health concerns. There are 17 CCCs statewide, each co-chaired by a parent/caregiver and a provider that work to address the needs of children with special needs and mental health concerns from birth to age 22. The council's individual efforts are supported by the government agency within DOE that provides technical assistance to the council and convenes statewide quarterly meetings so issues raised from the community can be addressed at a statewide forum.
- *The Special Parent Information Network (SPIN)* is funded by DOE and housed in the DOH. SPIN provides resources and supports for families and convenes an annual conference for parents and providers.
- *The University of Hawaii Center on Disability Studies* received a family engagement grant in conjunction with DOE and is focused on teaching schools on how to include parents rather than just empowering parents. This grant is working to create Family Engagement Centers to bring together families, schools, and communities to support children and youth.
- *The Hawaii State Council on Disabilities (DD Council)* consists of 28 governor-appointed members that includes individuals with Intellectual and Developmental Disabilities (I/DD) parents, family members, and representatives from public and private agencies that serve this population. The council engages communities in advocacy, capacity-building, and systemic change activities that are consistent with the policy in the federal law.

There are several nonprofit groups that support family leadership and development. Not all are captured here but these agencies represent some of the statewide initiatives existing in Hawaii:

- *The Parent Leadership Training Institute (PLTI)* is a program of HCAN, a nonprofit focused on improving child outcomes. PLTI is an evidence-based civic engagement curriculum that provides parents and community members with the confidence and skills to participate in efforts to improve the policies and systems that serve their families and communities.
- *The Leadership in Disabilities and Achievement of Hawaii (LDAH)* receives funding from the Office of Special Education (OSEP) to be the state's Parent Training Institute (PTI). As a PTI, LDAH and its partners provide information and referral, mentoring and advocacy, and education and training to parents and family members of children with disabilities and the professionals who serve them. This organization helps support families with children birth through adolescents with the goal to ensure all children with disabilities receive a proper public education.
- *Hawaii Families as Allies (HFAA)* establishes parent support groups statewide. It is a local chapter of the National Federation of Families for Children's Mental Health. The mission of HFAA is to provide authentic peer and family support to family members, parents, and caregivers in need. Because the organization is run by families who have experienced the system firsthand, they understand the challenges faced when raising a child, youth, or young adult and use their lived experiences to guide other families forward.
- *The Family Hui Hawaii* is a parent-led organization that supports community-based support groups throughout the state. They promote family-based "hui," or groups, to support parents with resources and social support. Because of the pandemic, the Hui introduced "Hui bubbles" where families participating can follow state

- guidelines on gatherings, providing social connections and support between families within their communities.
- *The Hilopa'a Family to Family Health Information Center* is staffed by parents and friends of children with special healthcare needs, and they provide information, referrals, technical assistance, and training for parents. This organization is also the Ombudsman for the Hawaii State Medicaid Programs and in this capacity, they can help families articulate their needs for their children's healthcare.

FHSD met with representatives from the government and nonprofit organizations to determine how to effectively engage families and compensation/support practices for family members who serve on committees or advisory groups. Parents are often called on to share their life experience/expertise as consultants without compensation, and some have long-standing relationships with their communities and serving as community leaders. Policies and guidelines for compensation are needed to ensure diverse family involvement.

Convening Parent Organizations: The Hawaii ECCS HIPP grant will seek to strengthen partnerships with these groups to share best practices and coordinate efforts to expand parent engagement. The group decided to continue meeting and will convene as part of the grant as a Parent League Advisory (the name of the group is subject to change based on consensus of the group). It is envisioned that this league will help to address common barriers, systemic challenges, and opportunities to move forward together. ECCS HIPP funds will be used to help staff this collective of family agencies/programs.

ECCS HIPP award/plans: The ECCS HIPP grant was awarded to Hawaii in May 2021. Plans include the development of multiple ways for parents and community members to contribute and participate in the grant's early childhood system-building program and policy decisions. Flexibility is needed since most parents in Hawaii are juggling multiple responsibilities and an ever-changing COVID environment. There are varying degrees to which parents may be interested and able to contribute their views and experiences.

The Hawaii ECCS HIPP grant will also use social media to engage parents and families. Parents that are social influencers will be recruited to assist with recruiting other parents who are normally hard to reach and hard to engage in meetings and workgroups. These parents may be willing to provide valuable feedback on their experiences with maternal and child support services. Agencies will be asked to support parent leaders and to bring parents to share their perspectives on various topics affecting the system of care. The intimate familiarity that users of the system can share is invaluable to improving the system.

Title V Family Leader: Over the past 10 years, Leolinda Iokepa has served as Hawaii's Title V family leader. She is imminently (and uniquely) qualified to serve in this position as she also serves as lead for F2FIC; the former principal investigator for the MCH LEND grant; lead for Hawaii's Family Voices; and has a young adult son on the autism spectrum. Her expertise is widely sought by numerous public/private healthcare and family support agencies. She has served as the state Medicaid Ombudsman; training consultant for the state Developmental Disabilities program and Developmental Disabilities Council; advisor for health insurer quality improvement initiatives; trainer for the state 'No Wrong Door' coordinated service/referral system; and family/community engagement consultant for several Hawaii Title V needs assessments and CSHN program projects. Throughout 2020-2021, Ms. Iokepa's availability was hampered by medical and family issues. FHSD is working to identify a replacement for her services and expertise.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

Over the past two years, FHSD has been without any epidemiology support. Previously, the division had two division-level epidemiologists who provided critical guidance and support specifically to the Title V and SSDI grants, PRAMS program, as well as overall technical assistance to FHSD programs with data presentations, research, and publications.

In December 2018, Don Hayes, the Centers for Disease Control and Prevention MCH Epidemiology assignee, resigned after accepting a job offer at CDC Atlanta. Later in August 2019, Tiana Garrett-Cherry, FHSD's Division Epidemiologist II, resigned to relocate to Virginia.

FHSD has aggressively worked to fill both positions to no avail. FHSD continues to seek another CDC MCH Epidemiology assignee. Although an interview with a promising candidate was conducted in September 2019, the candidate did not accept the job offer due to salary issues. There were no prospective candidates in FY 2020. Hawaii submitted another CDC request in FY 2021, but no candidate has been found at this time that meets Hawaii's requirements.

Initially, FHSD actively recruited for the Epi II position but was not able to find a viable candidate. In 2020, the position was under a statewide hiring freeze due to the pandemic. FHSD resumed recruitment for the position in July 2021 when the freeze was lifted.

FHSD does have three FTE research statistician positions located at the division and CSHN and MCH branches that provide data analysis support and consultation. Carlotta Fok, Ph.D., has served as the division research statistician since 2016. She received her Ph.D. from McGill University, Canada, in quantitative psychology in 2006 and was a postdoctoral fellow and then a research scientist at the Center for Alaska Native Health Research (CANHR), focusing on health disparities research, cross-cultural measurement development, theory testing, and analysis of intervention effects. Her expertise is in longitudinal and functional data analysis, measurement development, small sample methodology, and developing quantitative methodology for program evaluation. She provides statistical assistance and data analysis for the Title V and PRAMS programs. Dr. Fok works with the DOH vital statistics office to draw the PRAMS monthly sampling.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The primary purpose of the State Systems Development Initiative (SSDI) grant is to develop, enhance, and expand state Title V MCH data capacity to conduct needs assessment and performance measure reporting for the Title V MCH Block Grant program. The eight key MCH datasets identified in the SSDI grant are used for surveillance, needs assessment, planning, public education, and evaluation.

Access to Key Datasets: Form 12 provides information on Hawaii's ability to access these datasets electronically, routinely, and in a timely manner. The form also tracks linkage of the datasets with birth records, where appropriate. This narrative reflects reporting on Year 4 of a five-year project period (12/01/2020 – 11/30/2021).

Generally, Hawaii had consistent access to most of the SSDI datasets on a regular basis with a few exceptions: Medicaid and hospital discharge data. Electronic datasets were available for newborn screening programs, PRAMS, and vital statistics. In 2020, FHSD lost access to the WIC electronic dataset.

Vital Statistics: In 2017, enforcement of a Hawaii Revised Statute (HRS) related to data-sharing policies severely limited and stopped data sharing from the Hawaii Vital Records office. In 2018, FHSD helped pass legislation to amend the statute and in March 2019, FHSD was able to regain access to the electronic vital statistics dataset upon approval by a new DOH Institutional Review Committee, established by the new statute.

PRAMS: While changes were made to the data sharing statute, the Hawaii PRAMS survey operations were halted for 18 months over 2017-2018 without access to birth records to draw the survey sample. Survey operations resumed in December 2018; thus, there are no Hawaii PRAMS data for the years 2017 and 2018. Additionally, issues with the 2019 sample resulted in only six-months of useable data. 2020 will be the first full year of PRAMS data since 2016.

WIC: In 2020, WIC completed installation of its new data system. A private third-party vendor now houses, analyzes, and reports data for the WIC program. The FHSD WIC Branch no longer has direct access to the electronic dataset but does have regular access to standard and special data reports.

Hospital data: In 2021, FHSD received access to a new hospital data portal established between DOH and the new state hospital data administrator, the Laulima Data Alliance. The Data Alliance is a subsidiary of the Healthcare Association of Hawaii (HAH), the nonprofit trade organization serving Hawaii's hospitals, skilled nursing facilities, assisted living facilities, home care companies, and hospices. The data portal has proven difficult to navigate; FHSD continued to use SSDI funds to purchase hospital datasets, when needed.

Data Linkage: Hawaii has annual access to one linked electronic dataset: birth and death records. Currently, Hawaii has no plans to establish any new data linkages without epi staff and because COVID-related priorities. In the past, newborn screening and WIC datasets were linked to vital statistics. These linkages may be explored again when feasible. Hawaii SSDI linkage activities in project years one through three focused on the development of a state All Payers Claim Database (APCD), which includes Medicaid, Medicare, and State Employee Union claims data. The project is being managed by the Data Analytics Group at the state Medicaid program; however, no updates from were available on this project.

Epi Staffing: SSDI data activity is limited due to the departure of FHSD's two epidemiologists: Don Hayes, MPH., M.D., a CDC MCH Epidemiology Assignee and Tiana Garrett-Cherry, Ph.D., MPH. Hawaii continued to recruit for the position vacancies but was unsuccessful to date. FHSD contracted with Dr. Garrett-Cherry in 2020 to provide data analysis to complete the 2020 Title V needs assessment and draft several data products. Although the needs

assessment was completed in 2020, the final publication of the factsheets was not completed due to COVID-related issues.

Needs Assessment: SSDI funds were used to contract Elizabeth McFarlane, Ph.D., a University of Hawaii Public Health faculty member, to assist with ongoing needs assessment work since the 2020 Title V assessment was completed before the COVID pandemic. Dr. McFarlane specializes in MCH and completed Hawaii's Maternal, Infant, and Early Childhood Home Visiting needs assessments. She also routinely provides technical assistance and serves as a Title V grant reviewer for the Pacific Jurisdictions Title V programs.

While there is little 2020 health data available at this time, Dr. McFarlane assisted with the review of available data from the U.S. Census Pulse survey, state socio-economic, and data from a few 2020 Hawaii surveys conducted to assess COVID impacts. The data helped support the selection of four new Hawaii Title V priorities: child wellness visits/immunizations, child/youth mental health, food insecurity, and telehealth access.

Additionally, Dr. McFarlane helped design and administer a survey of all Hawaii Title V programs to capture systematic information on COVID impacts across FHSD programs and neighbor island offices. Results of the assessment are summarized in the Overview and Needs Assessment narratives of this report. A final report will be completed by November 2021.

Lastly, Dr. McFarlane will finalize the 2020 needs assessment data publications that were drafted by Dr. Garrett-Cherry.

Planning/Evaluation: FHSD continued to use SSDI funds to contract for technical assistance (TA) to help Title V issue leaders/staff with evaluation and planning for the Title V performance measure strategies. From 2018-2020, Hawaii partnered with University of Hawaii Office of Public Health Studies (OPHS) faculty to develop logic models for each of the Title V priorities to assess program progress, achievement of short- and long-term outcomes, identification of barriers/challenges, and ensure the alignment of strategies with Title V measures. This followed a recommendation from a 2018 AMCHP skills-building session.

In FY 2021, SSDI funds were used to continue TA for staff by Nancy Partika. Ms. Partika served as faculty for the former MCH Certificate program at OPHS. She also has extensive public health experience working for the Department of Health as well as leading community nonprofits like Healthy Mothers, Healthy Babies. Her TA supported building staff public health knowledge and helped staff assess and respond to the challenges posed by the COVID pandemic. Ms. Partika also assisted staff with the review of research by the MCH Evidence Center (EC) to support strategy selection and promote health equity. She developed a resource list of best practices for staff to advance health equity.

MCH Data Tracker: The SSDI grant also helped fund a contract with the Hawaii Children's Action Network (HCAN) to plan and design a high-level MCH data tracker. The intent of the tracker is to provide a quick overview of data to help monitor key health MCH indicators and population demographics as the 2020 data becomes available. Most available health data is from 2019, pre-pandemic. Going forward, it will be important to monitor COVID-19 impacts on MCH health across a broad spectrum of indicators and to make this data easily accessible. The tracker will draw upon data from the SSDI MCH datasets, including vital statistics, PRAMS, as well as Title V measures and Census data. HCAN is also the new state Kids Count administrator and is exploring the revision of the Kids Count website to make it more user friendly. Thus, there is an opportunity to coordinate data reporting for community use.

After an initial meeting with the Kids Count advisory committee, it was decided an internal FHSD data advisory group should be convened to develop the scope of the MCH data tracker and then meet with the Kids Count advisory

committee for coordination. The Hawaii MCH Family-to-Family Center director will facilitate FHSD discussions to also include a family perspective.

Oral Health data: SSDI funds were used to purchase 2020 data on Emergency Department (ED) visits related to oral health conditions in response to requests by the state oral health coalition. The data will be analyzed and shared with stakeholders later this year to determine the impacts of COVID on access to preventive dental care since ED dental-related visits are largely preventable.

Child/Youth Mental Health data: Another small contract with HCAN was executed to assist with compilation of data on child/youth mental health in response to growing concerns over the impact of COVID restrictions on this area of health, particularly with the cancellation of in-person learning for Hawaii's public schools. Most of the available data was from 2019: Youth Behavioral Risk Survey, National Survey on Child Health, and Medicaid Quality Assurance Measure for Child Mental Health. FHSD was able to partner with the DOH Injury Prevention program epidemiologist to analyze Hawaii ED data for 2020 for youth suicide-related ED visits. Also, results from a 2020 DOH survey to assess mental health needs of adults, sponsored by the behavioral health program, was also included. The data was used to support Hawaii's grant application for the HRSA Pediatric Mental Health Access grant and will be used for a factsheet planned for FY 2022.

Data Products/resources:

Without epi staff, FHSD data products have been somewhat limited.

Factsheet

- Fok, C.C.T., Awakuni, J., & Shim, M. J. *Unintended Pregnancy Fact Sheet*. Honolulu, HI: Hawaii State Department of Health, Family Health Services Division; 2020.

Manuscripts

- Fok, C. C. T., & Shim, M. J. *Prevalence and Risk Factors for Adolescent Suicide Attempts in Hawai'i*, YRBS 2015-2017. Submitted to Hawai'i Journal of Health & Social Welfare.

2020 Preparedness Summit Poster

- Disaster preparedness among postpartum women in Hawaii, Results from the Pregnancy Risk Assessment Monitoring System (PRAMS), 2016 (Penelope Strid, Carlotta Ching Ting Fok, Marianne Zotti, Holly Shulman, Jane Awakuni, Duane House, Brian Morrow, Danielle Vassalotti, Judy Kern, Matthew Shim, Sascha Ellington).

Websites/Data Trackers

Hawaii State Department of Health, Hawaii Health Data Warehouse, Pregnancy Risk Assessment Monitoring System. Data for 2000-2016. <http://hhdw.org/health-reports-data/data-source/prams-reports/>.

Hawaii State Department of Health, Pregnancy Risk Assessment and Monitoring System (PRAMS). <https://health.hawaii.gov/fhds/home/hawaii-pregnancy-risk-assessment-monitoring-system-prams/>.

Hawaii State Department of Health, The Hawaii Primary Care Needs Assessment Data Tracker www.hawaiihealthmatters.org/Dashboards/PCNA. This convenient online tool allows users to compare common health statistics across all 35 primary care service areas in Hawaii. It includes over 45 indicators of population characteristics and health status to monitor an area's social determinants of health. The tracker includes a short section on Maternal Infant health utilizing vital statistics birth and infant death data.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

FHSD executed several state-funded contracts in FY 2021 to secure services for data collection and analysis as well as development of data sharing products and publications.

CSHN Ongoing Needs Assessment: University of Hawaii Center for Disabilities Studies (CDS) will be conducting ongoing assessment to capture impacts of the COVID pandemic on CSHN and their families. CDS will also build upon the initial secondary data analysis from the 2020 assessment and expand data analysis and review of survey and administrative data sources including Department of Education special education data.

The findings will be used by FHSD CSHNB to inform general program planning and policy and identify opportunities for collaboration to strengthen and expand services to improve CSHN population health. The findings will also inform Title V priority selection, strategy development, and guide design of effective transition planning messaging for YSHN. Input and engagement from YSHN and their families will be integrated in all aspects of the project scope when possible. Several data products will be produced.

Data Publications & Analysis: University of Hawaii Office of Public Health Studies (OPHS) OPHS faculty will assist with completion of several data products from the 2020 needs assessment, including population domain factsheets, Title V priorities factsheet with data, and several informational briefs on maternal morbidity/mortality, MCH mental health, and Adverse Childhood Experiences. Data analysis will be conducted on 2019 Behavioral Risk Factor Surveillance Survey data questions purchased by FHSD on oral health and family planning.

Oral Health Tracker: University of Hawaii OPHS manages the DOH Data Warehouse. The Warehouse contains a user-friendly website, *Hawaii Health Matters*, that contains several data trackers. OPHS will assist Title V to convene an oral health data advisory group to select key indicators for an oral health data tracker and design/develop the tracker. OPHS will also help promote and present the tracker to community stakeholders.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

Hawaii Emergency Management Structure

Statewide: The Hawaii Emergency Management Agency (HI-EMA), located in the state Department of Defense, is the emergency management agency for the State of Hawaii. The Governor has direct authority over HI-EMA which serves as the coordinating agency for all county emergency management agencies, federal emergency management agencies, state departments, the private sector, and nongovernmental organizations.

HI-EOP: HI-EMA develops and maintains the State of Hawaii Emergency Operations Plan (HI-EOP), which is an all-hazards plan that establishes the shared framework for the state's response to and initial recovery from emergencies and disasters. State agencies responsible for providing emergency assistance are organized into 16 functional groups, state emergency support functions (SESF). Each SESF outlines responsibilities of state agencies and partners for emergency functions and provide additional detail on the response to specific types of issues and incidents.

The last HI-EOP basic plan was completed in 2017 and was revised/updated several times through 2019 prior to the pandemic. By statute, the HI-EOP is updated every two years.

State Departments: Additionally, each state department has a EOP to address how each department will manage the impacts of an emergency on its operations and execute duties assigned by the HI-EOP.

Counties: Counties develop their own EOPs that is consistent with the HI-EOP and provides guidance on the utilization, direction, control, and coordination of local resources during emergency operations and address mechanism for requesting and integrating state support when local resources are not sufficient.

Department of Health (DOH). Within DOH, the lead for emergency management is the Office of Public Health Preparedness (OPHP) which is located directly under the Director of Health. OPHP works to prevent, mitigate, plan for, respond to, and recover from natural and human-caused health emergencies and threats. Prior to 2018, the OPHP was a branch under the Disease Outbreak Control Division (DOCD). However, this organizational location limited OPHP functions to disease-related emergency and response activities. The removal of OPHP from the DOCD allows the program to serve and support the entire Department, including Environmental Health, under the direct command of senior leadership for broad emergency response.

OPHP comprises 20 core staff, statewide and also funds positions at the State Laboratory and DOCD. OPHP also manages the state Medical Reserve Corps (MRC) that may provide volunteers to assist with emergency operations.

DOH in HI-EOP: In the HI-EOP, DOH has a lead role for SESF 8, Public Health and Medical and ESF 10, Oil and HAZMAT response. During a response, SESF representatives work with HI-EMA and other state, county and federal agencies to manage the incident.

DOH-EOP: The OPHP is responsible for developing and maintaining the DOH's emergency operations plan (EOP). Plan review is conducted yearly following the end of the annual hurricane season based on lessons learned from real events and from exercises. The latest plan was completed in 2019 before the COVID pandemic. Title V was not directly involved in the plan development but is provided an opportunity for review and input.

Maternal Child Health (MCH): Both the HI-EOP and HI-DOH have limited language that specifically addresses the needs of maternal and child health. There is also minimal language for those with access and functional needs, which can include pregnant women and children. In the situational analysis, HI-EOP does acknowledge certain populations

that are particularly vulnerable to the impacts of emergencies, including individuals with disabilities or access and functional needs and people with limited English proficiency:

- Individuals with disabilities and others with functional and access needs must be considered in emergency planning. Approximately 11% of Hawaii's population has a disability. Nearly 50% of residents over the age of 75 are disabled
- Approximately 26% of residents speak languages other than English at home and 18% of the population is foreign born.

Incident Management Structure (IMS)

HI-EMA When an imminent or actual emergency threatens the state, HI-EMA coordinates the state's response through the activation of the State Emergency Operations Center (SEOC) and the State Emergency Response Team. The Title V director served as the DOH EMSF-8 (Public Health & Medical) liaison to the SEOC prior and during the pandemic.

DOH During an emergency, the DOH establishes an emergency response structure to coordinate DOH's activities using national IMS guidance – Department Operations Center (DOC). The OPHP trains DOH staff to fulfill leadership roles in the DOC for planning, operations, and logistics section chiefs as well as section staff. Members of the Family Health Services Division (FHSD) have been trained on, and served in, emergency management leadership roles before and during the pandemic as Section Chiefs in the DOC.

Hawaii's Title V Director has served as the DOC Planning Section Chief; while FHSD's Administrative Officer has served as the DOC Operations Section Chief. As the pandemic has proceeded, Title V's representation of the DOC has been revised to focus of COVID-related emergency response.

AMCHP Emergency Preparedness and Response Learning Collaborative (ALC)

In 2019, Hawaii was fortunate to participate in an AMCHP Emergency Preparedness and Response Learning Collaborative (ALC) opportunity to address the maternal and infant health population. A team was recruited for the collaborative including representatives from the Title V agency (CSHNB staff), OPHP, the DOH Planning Office; Hawaii's Medicaid agency; and a University of Hawaii Public Health doctoral student. Initially, the goal of the Hawaii team was to provide an appendix to the state emergency plan regarding maternal and infant health, but was revised to develop an evidence-based, comprehensive strategic plan that integrates communities and stakeholders that is supported by senior leaders.

There were several strengths of the ALC on Emergency Preparedness and Response for Maternal & Child Health (EP&R MCH), including:

- AMCHP provided training sessions, technical assistance and an opportunity for several of the team members to network with ALC peers
- Guidance and leadership was provided which facilitated discussion on specific and overlooked areas of need.
- The completion of training sessions, reports and a checklist that highlighted the gaps in planning nationwide.
- The multidisciplinary nature of the Hawaii team created broader insight.

Two of the most beneficial outcomes of the ALC were:

- brought awareness to the topic of EP&R MCH for those in the ALC, who in turn spread awareness to other colleagues and partners, and
- it allowed for the creation of new professional relationships that are/will be critical in a response. The latter was of benefit during the COVID-19 pandemic when information and resource dissemination were needed.

There were also several areas of improvement identified during the ALC:

- The lack of understanding from both internal and external partners in Hawaii (outside of the team) of the specific needs of pregnant and post-partum women, infants and children during an emergency or disaster. This made it difficult for the team to garner support to meet its primary objective, as well as complete secondary tasks in a timely fashion.
- There is a lack of data in this area, from which to assess needs specific to Hawaii. There are EP&R questions in the Hawaii PRAMS survey, but more data collection is needed.
- Greater support to build awareness at a senior level within the Department and across Departments is needed. This would underscore the need to revise emergency plans to include this population, which requires support from the partners involved in writing and implementing plans.
- There is a need for continued technical assistance in general, and for guidance in developing strategies in particular.
- There is a need for additional staff to champion the efforts.

Secondary tasks and projects that came out of the initial ALC focused on outreach materials and included an informal presentation to Community Health Center (CHC) leadership, along with a survey. The survey found the CHCs would distribute such materials if it was produced and provided to them. Another survey to the local chapter of the American College of Obstetricians and Gynecologists (ACOG) was planned but was stalled due to pandemic response efforts.

Although, the AMCHP ALC concluded several years ago, the Hawaii team continued to meet monthly until the pandemic, after which meetings have become sporadic. Membership has evolved and includes members from the State Breastfeeding Workgroup (Nest for Families).

The Hawaii ALC group helped disseminate a COVID-19 handout for pregnant and breastfeeding women and helped translate it into several languages for statewide use. The need for this emerged from Medical Reserve Corps (MRC) volunteers who were providing food and baby supplies to families in home isolation and quarantine. The needs of families with infants was distinct from other families and individuals: baby food, distilled water, diapers and cleaning supplies. Pregnant women also had special needs. MRC volunteers were questioned about disease transmission, specific to their situation. The information was used by MRC volunteers for these families when supplies were provided.

[COVID-19 Lessons \(to date\)](#) The COVID-19 pandemic identified gaps in planning and operations for many vulnerable and disparate populations, many of which will continue to be addressed. Pregnant women were a population that required special consideration for disease implications. Mental health for pregnant, post-partum and lactating women may also have been impacted, as hospitals and birthing centers restricted visitors and social distancing created a feeling of emotional isolation for many.

Birth plans needed to be altered and medical visits may have brought increased concern for disease exposure. In addition, not all families had post-birth support from extended family due to social distancing, quarantine and isolation. Due to the novelty of the disease, there was a dearth of data on the effects of COVID-19 for pregnant and lactating women. There was also a need to have information translated into multiple languages. All of these issues left families concerned or unsure of how the disease would impact them and their baby.

[Title V Preparedness Efforts](#) Hawaii's Title V Director participated in the development of the State COVID vaccination plan and served as the liaison for the early childhood/childcare providers to ensure priority vaccination status was given to this sector. He also provided regular communication updates during the pandemic to members

of the early childhood community through the State Early Learning Board, which is a public-private governing board tasked with formulating statewide policy relating to early learning. FHSD programs and services helped share information with their constituents and providers and families as applicable.

During the pandemic, Title V programs provided leadership for their programs to develop policies and procedures in alignment with CDC and DOH guidance, federal and state mandates, and the governor's emergency proclamation orders. Adaptations to programs had to be considered for the health and safety of staff, families, and communities.

- [Newborn metabolic screening](#) worked with hospitals and families to ensure timely specimen collection for newborns. COVID had some impact on families and physicians because some doctors' offices were closed, and some families were afraid to visit hospitals and clinics. However, the program ensured most newborn screens were completed and identified missed babies for follow-up for screening. Infants at risk were transferred to a hospital or referred to Hawaii Community Genetics for follow-up care. The program maintained a screening rate of 99.8%.
- [Newborn hearing screening](#) continued to ensure babies had a hearing screening before one month of age and worked with the hospitals, hearing screening programs, and midwives. Hawaii saw higher rates of home births, possibly due to concerns over exposure to COVID-19 at hospitals. The program adapted to work closely with midwives to ensure hearing screenings were completed.
- [Home visiting](#) followed guidance from HRSA to suspend in-person home visits during the governor's mandatory closures. Home Visiting staff continued to support providers modify services and continue participant recruitment during the pandemic. Support was offered to providers to ensure equitable access to remote services for enrolled families. Home Visiting service programs continued to engage families using videoconferencing or through telephone calls to maintain contact with families while maintaining fidelity to the evidence based service models.
- [WIC](#) waivers were extended by the USDA, allowing Hawaii WIC clinics to provide all services remotely by phone, mail, and electronic correspondence. Hawaii WIC temporarily added new shelf-stable foods during times when certain items were hard to find or were unavailable in stores. Hawaii completed rollout of eWIC, the electronic benefits transfer (EBT) system, that replaced use of paper checks. The WICShopper app was made available for download that allows participants to review available food benefits, scan products to identify WIC-allowed foods, find WIC clinics, WIC-approved stores, and view recipes on a smartphone.
- [Early Intervention Section](#) (Hawaii's IDEA Part C Agency) services were modified to phone visits and/or videoconferencing. Zoom is used since it provides secure service versus FaceTime which does not meet confidentiality requirements.
- [Children and Youth with Special Health Needs Program](#) staff continued to communicate with youth and families through telephone, email, and videoconferencing and continue to check in with families to ensure their health concerns are being addressed.

[PRAMS Emergency Preparedness Data](#) In 2016, Hawaii was one of the first states to include an eight-part, pre-tested, standardized disaster preparedness question that measured family preparedness behaviors on their PRAMS questionnaire. The eight preparedness behaviors can be generalized into three categories: having plans, having copies of important documents, and having emergency supplies. A CDC Division of Reproductive Health intern analyzed the data for an Emergency Preparedness Summit and completed an unpublished manuscript. The results found Hawaii's mothers were relatively well-aware and prepared for emergencies with 79.3% reporting at least one preparedness behavior. The high rate was attributed to Hawaii's experience enduring severe hurricanes and the annual state hurricane season educational campaigns.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

Hawaii's Title V program and staff utilize a collaborative approach to leverage federal and state resources to assure healthcare services delivery capacity in the state. Hawaii partners with many public and private entities to promote optimal health and contributes to the building of the healthcare system. FHSD works at all levels of service (direct, enabling, and infrastructure building) to assure healthcare service delivery statewide.

FHSD assures a statewide system of care through provision of safety-net and gap-filling community-based services through purchase of service contracts or subsidies.

[Perinatal Support Services Program \(PSS\)](#) provides support services and resources for high-risk pregnant women. The goal for the Perinatal Support Services Program is to promote health education, best practices, and increase the likelihood of positive birth outcomes. The objectives of the program include increasing early prenatal care; decreasing incidence of preterm, low, and very low birth infants; and improving the health of the participants. This program provides services for pregnant women before, during, and after pregnancy (up to six months after birth). These contracts will end July 1, 2021 and will be replaced with new RFP for State Reproductive Health Care and Support Services that combines state matching funds for Hawaii's former Title X family Planning program and PPS funding.

[Hospital Subsidies](#) are supported by state general funds and administered by FHSD to the following entities.

- [Hana Urgent Care](#) - In partnership with American Medical Response and Maui Memorial Medical Center, Hāna Health provides urgent medical care around the clock. As the only medical provider in the district, Hāna Health physicians are on-call 24 hours a day, 7 days a week, 365 days a year.
- [Waianae Coast Emergency Services - the Health Center's Emergency Department](#) has operated at its main site in Waianae since 1975 and has provided 24-hour emergency services since 1986. Recognized as a Trauma Support Facility by the state of Hawaii, it serves as a critical safety net for the residents of the Leeward coast. For the period July 1, 2016 – June 30, 2017, the ED registered 24,687 patients of which 89% were residents of the Waianae Coast.
- [Wahiawa General Hospital](#) is a community-owned, nonprofit hospital serving Wahiawa and the communities of Central Oahu and the North Shore. It is the community's most comprehensive healthcare facility.
- [Molokai General Hospital](#), a member of The Queen's Health Systems family of companies, is the only hospital on the island of Molokai, providing 24/7 care for the island's 7,500 residents and visitors. Services include a blood banking laboratory, digital CT, digital x-ray, digital mammography, outpatient chemotherapy, acute care, skilled nursing physical therapy, and a full-service midwifery program.

[Community Health Centers](#) - Funded by the Community Health Center Special Fund for contractual services to improve access to healthcare for medically underserved populations through Federally Qualified Health Centers (FQHC). The array of services includes primary care, mental health care, dental health care, and pharmacy. The core mission of FQHCs is to provide access to primary care services for the most vulnerable populations, regardless of the ability to pay. These services are sometimes known as safety net services and are provided to uninsured and underinsured individuals at or below 250% of the federal poverty level. Access to primary health services reduces morbidity and mortality by providing timely, appropriate, and less expensive care, and thereby preventing the development and exacerbation of serious health conditions.

FHSD's Office of Primary Care and Rural Health assure a statewide system of care and supporting workforce needs.

- [State Primary Care Office \(PCO\)](#): Funded by the federal Bureau of Health Workforce to designate statewide

health professional shortage areas that increase eligibility of skilled healthcare professionals for federal and state scholarships and loan repayments in exchange for a commitment to work in needy communities. This makes it possible for healthcare providers to recruit and retain health professionals, thereby improving the health of underserved and vulnerable populations.

- [State Office of Rural Health \(SORH\)](#): Funded by the federal Office of Rural Health Policy to create a focal point for rural health issues within each state, linking communities with state, federal, and nonprofit resources and helping to find long-term solutions. Program goals include educating providers about new healthcare initiatives, collecting and disseminating data and resources, and supporting workforce recruitment and retention.
- [Medicare Rural Hospital Flexibility Program \(FLEX\)](#): Funded by the federal Office of Rural Health Policy for strategic planning activities with an emphasis on quality and financial and operational improvements for Hawaii's Critical Access Hospitals (CAH). This assists small rural hospitals to improve access to health services in rural communities via data tracking, analysis, and benchmarking toward quality improvement. Contracts for rural hospitals provide essential access to inpatient, outpatient, and emergency medical services in rural communities.

In a 2021 survey of Title V program managers, a majority of direct service managers reported modifying service contracts during pandemic primarily to allow for greater flexibility in spending for personal protection equipment (PPE), workplace safety and personnel costs and allowing for billing of telehealth/remote services.

Developing critical statewide partnerships and system-building efforts. At the leadership level and serving on commissions and boards, Title V staff participate in efforts to meet the needs of women and children.

- The [Early Learning Board \(ELB\)](#) is tasked with formulating statewide policy relating to early learning and is responsible for directing the Executive Office on Early Learning (EOEL) on how to best meet the developmental and educational needs of children from prenatal care to entry into kindergarten. Title V Project Director, Matthew Shim, serves on the as an ex officio member
- [Hawaii Early Intervention Coordinating Council](#) advises the Early Intervention Section and is established as required by state law and Part C of the Individuals with Disabilities Education Act. This council is responsible for helping to develop the programs and services and system for children with special needs in partnership with families.
- [The Hawaii Maternal Infant Health Collaborative](#) is a public-private partnership committed to improving birth outcomes and reducing infant mortality. Hawaii's Maternal and Child Health Branch staff sit on the Steering Committee and chair workgroups.

Improving quality to assure services are family-centered, culturally relevant, and community-based (contract monitoring, program evaluation).

- [Hawaii's Home Visiting Program](#) promotes the use of evidence-based home visiting programs through the Maternal Infant Early Childhood Home Visiting (MIECHV) model, manages contracts, and ensures programs maintain fidelity to their model and meet benchmarks set by MIECHV. Currently, there are six contractors who provide services statewide.
- [Early Intervention Section](#) provides services required by Individuals with Disabilities Education Act Part C through a mix of EIS programs and contracted providers and ensures their services are family-centered and community-based, which are tenets of IDEA. Currently, there are four state-run programs and 15 contracted agencies. As part of federal reporting, contractors can see all the data across programs and indicators.

Assuring development/dissemination of public health messaging.

- The [Hawaii Childhood Lead Poisoning Prevention Program](#) developed a variety of materials for parents, providers, and community members. Many of these materials are in 12 different languages.
- Hawaii's [Adolescent Wellness Program](#) staff networks with public and private groups, community organizations, and youth to provide training and technical assistance relating to adolescent health and wellness, recently supporting TeenLink Hawaii to develop a website resource for teens with social media and videos to support teens, parents, and providers.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

In 2021, FHSD updated its 1995 Memorandum of Agreement (MOU) with MQD in compliance with the federal requirement for an inter-agency agreement between the state Title V program and the state Medicaid program. The agreement formalizes existing agency collaborative efforts to improve the health of mothers, children, and families and is an attachment to this report.



The new MOU does not require or direct any specific activity between the two agencies. Instead, it contains general language as suggested by the National Academy of State Health Policy to encourage ongoing collaboration to address health needs for the MCH population.

Many MCH and public health approaches are already embedded in the current state Medicaid program ("QUEST") waiver plan, the Hawaii Ohana Nui Project Expansion (HOPE). HOPE is a five-year initiative (2018-2022) to develop and implement a roadmap to achieve the vision of healthy families and healthy communities that aligns government agencies and funding around a common framework: a multigenerational, culturally appropriate approach that invests in children and families over the life cycle to nurture well-being and improve individual and population health outcomes. In vision and purpose, the HOPE plan mirrored the Hawaii State Department of Health 2015-2018 strategic plan, which contained a strong MCH focus. The following guiding principles describe the overarching framework used to develop a transformative healthcare system focusing on healthy families and healthy communities:

- Assuring continued access to health insurance and healthcare
- Emphasis on whole person and whole family care over their life course
- Address the social determinants of health
- Emphasis on health promotion, prevention, and primary care
- Emphasis on investing in system-wide changes

To accomplish the vision and goals, HOPE activities are focused on four strategic areas:

- Invest in primary care, prevention, and health promotion
- Improve outcomes for high-need, high-cost individuals
- Payment reform and alignment
- Support community driven initiatives to improve population health

In addition, HOPE activities are supported by initiatives that enhance three foundational building blocks:

- Health information technology that drives transformation
- Increase workforce capacity and flexibility
- Performance measurement and evaluation

Given Medicaid and DOH shared values and vision, collaboration between MQD and FHSD is fairly common. For instance, the two MQD staff completed the MCH Navigator workforce assessment and the MQD Q/I Community Relations Nurse subscribes to AMCHP newsletter and policy updates.

Examples of Title V partnerships activities in 2020 include:

Agreements

- CSHNB/Early Intervention Services (EIS) worked with MQD to amend/update the MQD-DOH MOA related to Medicaid payment for early intervention (EI) services.
 - The MOA includes appropriate coding and rates and adds the collaboration that will occur between the EIS Care Coordinator and MQD Health Plan Service Coordinator to ensure a smooth transition of clients from EIS to the next setting.
 - The MOA covers the period from January 1, 2021 through December 31, 2026.

- CSHNB/EIS collaborated with MQD on guidelines and role delineation for collaboration between EIS and QUEST Integration (QI) health plans.
 - A 3/3/17 MQD memo specifies a simple workflow outlining how and when information will be exchanged and a detailed side-by-side role delineation of the EIS Care Coordinator and QI Health Plan Service Coordinator.
- MQD clarified in its 5/31/17 memo that EIS may provide Intensive Behavioral Therapy (IBT) services to EI Medicaid children and will transition EI Medicaid children to QI health plans to cover Applied Behavior Analysis (ABA) services for Autism Spectrum Disorder (ASD).
 - An EI Care Coordinator and QI Health Plan Service Coordinator will collaborate on the transition.

Enrollment & Service Utilization

- Medicaid health plans promote WIC services to enrollees.
- Medicaid payment for specialty formulas and medical foods:
 - WIC is expected to be the payer of last resort for specialty formulas and medical foods.
 - Depending on medical plan and diagnosis, DHS/MQD will pay for entirely tube-fed WIC clients and possibly oral feeding.
- The MQD Medical director and QI/Member relations RN provide input on issues as that arise and are invited to participate in workgroups, including the workgroup developing a media campaign to promote child wellness visits related to the new HI Title V state priority.
- MQD are also supporting a media campaign to promote dental check-ups for children delayed by COVID in conjunction with the state oral health coalition. MQD will also share service utilization data for 2020 when available.
- Most Title V health service programs and contracts promote enrollment to Medicaid.

Title V Priorities

- The new Medicaid RFP includes Title V priorities screening for pregnancy intention, breastfeeding promotion, and development screening using standardized tools.
- Case managers from the largest Medicaid health plan, HMSA, are partnering with Title V to develop a transition to adult healthcare toolkit and media messaging for adolescent enrollees, especially for youth with special health needs.
- Working on a short timeline, Title V requested a partnership letter of support from Medicaid for the HRSA Pediatric Mental Health Access grant application and a meeting was quickly arranged with the Medicaid director on the proposal and scope of work.

Other Activities

- The MQD QI/Community Relations Nurse and Title V Women's Health Supervisor co-chair the Hawaii Maternal and Infant Health Collaborative (HMIHC) Pre-Inter Conception monthly workgroup overseeing this work.
 - HMIHC was instrumental in the issuance of a 2017 MQD policy supporting Title V evidence-based strategies: One Key Question® (OKQ) screening approach and Long-Acting Reversible Contraception (LARC). The policy also expanded access to contraception. HMIHC continues to work on implementing and evaluating the policy.
 - HMIHC was also instrumental in MQD issuing a provider policy memo supporting prenatal Screening, Brief Intervention, and Referral to Treatment (SBIRT) pilot project, requiring training and reimbursements for participating obstetricians.
- Since Project ECHO Hawaii is included in the HOPE plan, two Medicaid plans (AlohaCare, UnitedHealthcare) contributed funds to launch a new Hawaii Care Homes ECHO in April 2021. When a

COVID-19 outbreak at the Yukio Okutsu State Veterans Home on Hawaii Island claimed the lives of 27 residents and infected more than 100 senior residents and staff, Project ECHO Hawaii was able to stand up this new series to support geriatric healthcare providers and senior care facilities. Launched in 2016, Project ECHO Hawaii is a multi-organizational partnership between the Hawaii State Rural Health Association, University of Hawaii, and Hawaii State Department of Health.

- During the legislative session, FHSD and MQD often collaborate on the development of policy briefs and testimony. This year included work on a bill to fund maternal mortality data collection, which did not pass.
- FHSD receives MQD data for the Title V annual report/application including SSDI Minimum Core dataset Medicaid measures.
- The FHSD Primary Care office and DOH Data Warehouse presented the new Primary Care Needs Assessment Data Tracker to the MQD QI Nurse and Office of Enterprise Technology IT Officer and also discuss inclusion of MQD data in the future on enrollments and service utilization by age.

New Opportunities for Collaboration

- Customized letters (provider report cards) mailed to pediatric healthcare providers show how well providers are testing Medicaid recipients at 1 and 2 years of age for blood lead levels compared to other providers in the same area
 - This idea is used by other jurisdictions to make providers more aware of this federal testing requirement and increase testing rates. CSHNB/HI-CLPPP is exploring the idea and data sharing needs with MQD

III.E.2.c State Action Plan Narrative by Domain

State Action Plan Introduction

State Action Plan Introduction

The following section provides report and plan narratives for Hawaii's priorities, National Performance Measures (NPM), and State Performance Measures (SPM) by population domain as reflected in the 5-year plan.

Changes were made to Hawaii's Title V priorities because of the 2020 5-year needs assessment (completed before the pandemic) as well as additional changes resulting from ongoing needs assessment during the pandemic. Many activities planned for FY 2020 were impacted by the pandemic: delayed, cancelled or changed.

Hawaii's priorities discussed in this next section, by domain are listed below with the associated NPM/SPM number, the current status for FY 2020 (new, continuing and outgoing), and subject matter.

Domain	PM #	Subject
Women's/Maternal Health	NPM 1	Women's wellness visits
Perinatal/Infant Health	NPM 5 SPM 2 NPM 4	Safe Sleep New: Food Insecurity Outgoing: Breastfeeding
Child Health	NPM 6 SPM 1 SPM 5 NPM 13.2	Developmental Screening Child Abuse & Neglect Prevention New: Child wellness visits Outgoing: Child Oral Health
Adolescent Health	NPM 10	Adolescent Wellness Visits
Children with Special Health Care Needs	NPM 12	Transition to adult health care
Cross Cutting	SPM 3 SPM 4 SPM 1	New: Child mental health services New: State Telehealth expansion Outgoing: Telehealth for Title V programs

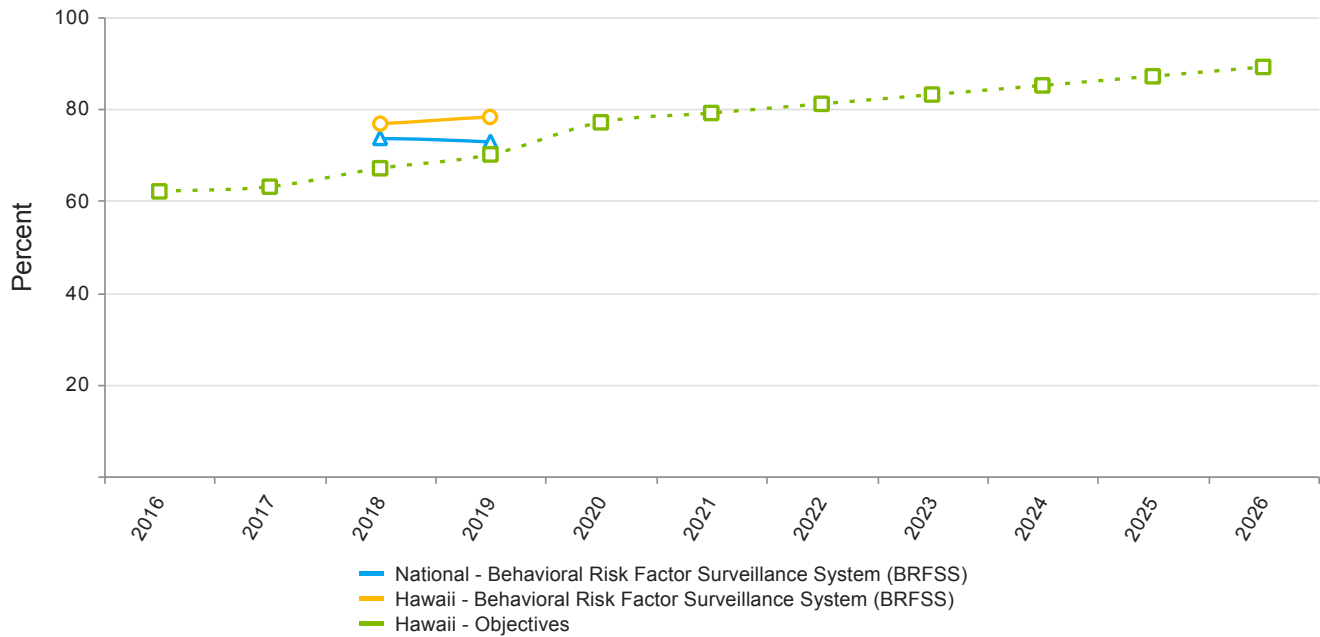
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	104.3	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	14.8	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	8.4 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	10.6 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	28.9 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	6.4	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	6.8	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	3.9	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.9	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	253.4	NPM 1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS-2019	6.8 %	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	1.3	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	15.7	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2019	11.1 %	NPM 1

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year Indicators and Annual Objectives



Federally Available Data

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

	2016	2017	2018	2019	2020
Annual Objective					77
Annual Indicator				76.6	78.1
Numerator				184,106	185,323
Denominator				240,287	237,398
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

i Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives

	2021	2022	2023	2024	2025	2026
Annual Objective	79.0	81.0	83.0	85.0	87.0	89.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of births with less than 18 months spacing between birth and next conception

Measure Status:					Active
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		34	31	31	31
Annual Indicator	32.7	31.7	31.9	30.9	32.4
Numerator	3,013	2,849	2,773	2,661	2,558
Denominator	9,225	8,974	8,693	8,599	7,903
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	31.0	31.0	31.0	30.0	30.0	30.0

State Action Plan Table

State Action Plan Table (Hawaii) - Women/Maternal Health - Entry 1

Priority Need

Promote reproductive life planning

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

By July 2025, increase the percentage of women ages 18 through 44 who had a preventive medical visit in the past year to 87%

Strategies

Promote women's wellness through systems building efforts

Promote pre/inter-conception health care visits

Promote reproductive life planning

ESMs

Status

ESM 1.1 - Percent of births with less than 18 months spacing between birth and next conception

Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Women/Maternal Health - Annual Report

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Introduction: Preventive Medical Visit

For the Women/Maternal Health domain, Hawaii selected NPM 1 Well-Women Visit based on the results of the 2015 five-year needs assessment. The 2020 Title V state objective is to increase the percent of women who have a preventive medical visit to 77.0%.

Data: The FY 2020 indicator (2019 data) is 78.1% of women in Hawaii received a preventive medical visit, which met the objective and was significantly higher than the national estimate of 72.8%. The BRFSS preventive checkup survey measure was revised in 2018 and is not comparable to previous survey years. There were no significant differences in reported subgroups by race/ethnicity, maternal age, household income, health insurance, or marital status based on 2020 data.

Objectives: Based on the 2020 needs assessment, this NPM will be continued into the 2021-2025 plan period. The state objectives reflect an annual increase of 2 percentage points.

The women's preventive medical or preconception wellness visit provides an important opportunity to receive recommended clinical preventive services (including screening, counseling, immunization), which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. The annual well-woman visit is endorsed by the American College of Obstetricians and Gynecologists (ACOG).

Title V Lead/funding: The Title V Women's and Reproductive Health Section (WRHS) in the Maternal and Child Health Branch (MCHB) provides the leadership for this issue. The Section Supervisor is partially funded by Title V along with the Family Planning Public Health Educator, Accountant, and Section Secretary. The programs in this section include Family Planning, Perinatal Support, and Adolescent Health. The Adolescent Health Supervisor is also partially Title V funded.

Strategies/Evidence: The strategies for this priority reflect in part the work of the Hawaii Maternal and Infant Health Collaborative (HMIHC), which provided leadership for women's health and perinatal issues in the state for the past eight years. Title V helped establish the HMIHC and is part of the organization's leadership team. The Title V strategies are:

- Promoting women's wellness visits through systems building
- Promote pre- and interconception healthcare visits
- Promote reproductive life planning

Research provided by AMCHP and the MCH Evidence Center show most evidence-based practices focus on clinical and direct service approaches rather than the broad systems-level strategies selected by Hawaii. However, Hawaii is implementing two evidence-based approaches that promote pre- and interconception care as well as women's wellness visits:

- One Key Question® (OKQ)
- Long-Acting Reversible Contraceptives (LARC)

The two approaches were promoted by the MCH Bureau Infant Mortality Collaborative Innovation and Improvement Network (ColIN) as best practices. Updates on the strategy activities for this NPM are discussed below.

COVID Impacts: With the risks of COVID-19, many healthcare providers closed temporarily to in-person visits with the governor's mandatory stay-at-home orders. Changing safety protocols and a shortage of PPE hampered many clinics from reopening. Healthcare services were limited to critical emergency care only and both providers/clients slowly moved toward telehealth visits. Fears of COVID-19 exposure from clients may also have resulted in appointment cancellations or delays. These factors contributed to the likely decrease in women's preventive wellness visits in 2020. The adverse economic impact of the pandemic on families shifted priorities to ensuring basic needs (housing, income and food security, employment) took precedence over preventive care and screenings.

Strategy 1: Promoting Women's Wellness Visits through Systems Building

This strategy recognizes public health issues are best addressed by developing and sustaining partnerships between community organizations, academic institutions, and government. These partnerships provide opportunities to improve the health of women before, after, and between pregnancies. In Hawaii, women's wellness is integrated into three major state plans and collaboratives:

- The Hawaii Early Childhood State Plan
- The Early Childhood Action Strategy Plans
- The HMIHC Strategic Plan

The state plans all embrace a life course approach that acknowledges the importance of women's wellness as a foundation for healthier birth outcomes and the health and well-being of infants, children, and families.

Early Childhood State Plan: The Executive Office on Early Learning (EOEL) early childhood state plan focuses on programs and services in state departments and public agencies. Maternal health is in the plan, recognizing that the overall foundations for early learning begin with access to quality prenatal care and women's health. Women's health activities include promoting preventive screenings for risk factors and assuring access to a medical home.

Early Childhood Action Strategy (ECAS): The ECAS is an independent nonprofit focusing on early childhood and pre-kindergarten programs. The initiative is a public-private collaborative comprised of over 100 professionals supporting child health, safety, development, and learning. There are six focus areas including Healthy and Welcomed Births.

Hawaii Maternal and Infant Health Collaborative (HMIHC): The HMIHC is a collaborative focused on improving birth outcomes, reducing infant mortality, and promoting intended pregnancies. The HMIHC strategic plan recognizes women's health as critical to its goals. Over 120 members participate in HMIHC including physicians, clinicians, public health professionals, community service providers, and health plan/healthcare administrators. HMIHC leads the ECAS Healthy and Welcomed Births focus area.

COVID response: Initially, COVID impacts disrupted routine ECAS and HMIHC meetings and activities. The ECAS network of partners devoted efforts to responding to the urgent relief and recovery needs generated by the virus. ECAS supported member organizations capacity building and assisted with direct family needs.

Strategy 2: Promote pre/inter-conception healthcare visits

This strategy focuses on the efforts of the HMIHC Pre/Inter-Conception Workgroup and the implementation of OKQ and LARC.

HMIHC Pre/Inter-Conception Workgroup: The Pre/Inter-Conception Workgroup focuses on promoting women's optimal health before and in-between pregnancies. It aims to reduce statewide unintended and untimed pregnancies by promoting comprehensive clinical, educational, and programmatic supports for reproductive life planning using culturally sensitive approaches and improving access to family planning services.

The Title V agency and state Medicaid office provide leadership for the workgroup that includes representatives from the Hawaii ACOG; University of Hawaii John A. Burns School of Medicine (JABSOM) Department of Obstetrics, Gynecology and Women's Health; Queen's Physicians Network; Hawaii Healthy Mothers, Healthy Babies (HMHB); Planned Parenthood; and federally qualified health centers (FQHC). The involvement of Medicaid and FQHCs assure services are prioritized toward low-income, high-risk women of reproductive age.

The workgroup tried to meet regularly virtually through 2020. Work on OKQ and LARC was delayed by COVID while FHSD and Medicaid focused on issuing new RFPs for services in 2020.

Medicaid Policies: HMIHC was instrumental in the issuance of Hawaii Medicaid provider policies in 2016 to support the use of OKQ and expand contraceptive coverage. The policy promoted the OKQ screening process and eliminated prior authorization for contraceptive procedures, methods or devices, and allowed reimbursement for a 12-month supply of oral contraceptives. The policy memo also unbundled LARC reimbursement from the global fee for inpatient delivery services, supported stocking of LARC in hospital pharmacies, and listed new billing codes for providers. The policy was disseminated to all Medicaid health plans, hospitals, pharmacies, and healthcare providers.

One Key Question® (OKQ): OKQ is a simple tool to engage women in a discussion about pregnancy intention by asking: "Would you like to become pregnant in the next year?" Depending on the woman's response, follow-up is based on a women's yes/no response or ambivalence about pregnancy following standard protocols. OKQ trainers are currently certified by the national *Power to Decide* (PTD) to utilize the training curriculum materials. OKQ is now used by a variety of Hawaii organizations/programs serving women of reproductive age to assess pregnancy goals and desires which often change over time. Client discussions can lead to reproductive planning and follow-up for preventive healthcare.

Prior to the pandemic shutdown, over 1,350 OKQ brochures and related materials were distributed through various events/activities but outreach and training activities were paused for the remainder of FY 2020.

Evaluation of OKQ: Each agency using OKQ currently collects implementation data. However, there is no systematic repository to compile the information or a standard set of indicators that measure the effectiveness of OKQ to prevent unplanned pregnancies and improve reproductive health outcomes. The HMIHC Pre/Inter-Conception Workgroup plans to obtain TA to develop an evaluation plan. Activities were paused for this activity during COVID.

LARC: LARC was chosen as an evidenced-informed approach by Hawaii to reduce rates of unintended pregnancy. LARC placement is conducted by a single visit/encounter and does not require additional medication or follow-up visits. Although LARC is considered a "highly-effective" form of contraception, practitioners are instructed to provide non-directive counseling and respect clients' decisions about use. Discussion of reproductive health intent/goals prior to or immediately following delivery can facilitate insertion of LARC at the hospital before discharge. This benefits women who are at-risk for short-interval pregnancies or those not likely to return for post-partum care.

The workgroup developed a LARC toolkit that includes billing guidance related to inpatient stocking of LARC and a chart with reimbursement codes. The information was broadly disseminated to birthing hospitals and providers.

Despite the Medicaid LARC policy, birthing hospitals have been slow to stock LARC devices. To support greater hospital use of LARC, HMIHC used a National Institute for Reproductive Health (NIRH) Grant to identify and address barriers and challenges. HMIHC has been working to address Medicaid's denial of reimbursements for hospital claims.

HMIHC continued working with several hospitals to establish in-patient pharmacy protocols to stock LARC. Funding was provided to assist hospitals with the initial stock startup costs. The goal is for all 13 Hawaii birthing hospitals to stock and receive unbundled Medicaid reimbursements for LARC inpatient insertion. Eight of the 13 hospitals now stock LARC for same day access.

LARC Provider Training: The Title V Family Planning program and JABSOM Department of Obstetrics, Gynecology and Women's Health conduct training for obstetricians/gynecologists and other practitioners on LARC insertion as well as counseling protocols. All of the Title V Family Planning Program providers are trained in placement and removal of LARC. No trainings were conducted in 2020 due to COVID restrictions.

Strategy 3: Promote reproductive life planning

This strategy focuses on increasing access to reproductive life planning services and assuring provision of family planning services through FHSD contracts for perinatal support services (PSS) and family planning (FP) service contracts.

COVID Response: With stay-at-home orders instituted in March 2020, Title V staff transitioned to teleworking. Changes to the FP and PSS contracts included:

- All MCHB Family Planning and PSS providers instituted or strengthened telehealth services to meet reproductive and other healthcare needs of clients.
- MCHB contracted service providers maintained clinic hours for family planning, perinatal support, and other health services during the COVID-19 pandemic for both in-person and telehealth services. MCHB assured contractors followed recommended safety precautions to protect employees and clients.
- MCHB extended Family Planning and PSS contracts through June 30, 2021, to assure continued funding and services through the pandemic.

Title X Funding Ended: After several months of deliberation with the governor's office, the attorney general, and DOH leadership, the Title X Family Planning program award (\$2 million) was returned to the federal Office of Population Affairs. This was in response to the Trump Administration's Title X conditions prohibiting grantees from providing any information regarding abortion services. Hawaii did not submit a Title X non-competing continuation application and was no longer a Title X grantee effective April 1, 2020. FP service contracts continued through June 30, 2021, using state funds. Title V funds helped support FP staff salaries temporarily.

Comprehensive Services Delivery Challenges: Family planning services are voluntary and include education and counseling, pregnancy testing, basic infertility services, preconception health, sexually transmitted disease/human immunodeficiency virus testing, and other related preventive health services including referrals as appropriate. Preventive health services include updating immunizations, blood pressure screening, weight management, domestic violence and intimate partner violence screenings, tobacco cessation, and cervical and breast cancer screenings. All clients are encouraged to return for their annual well-women exams to ensure health maintenance and other preventive health needs are addressed. During the pandemic, providers were challenged to provide comprehensive services given COVID shutdowns.

Clients Served: Despite changes to the contracts, the MCHB Title X FP program did serve 10,308 clients for FY

2020 over 17,096 visits. This was a slight reduction in the number of discrete clients (from 11,879 in 2019), but there was an increase in overall visits (from 15,919). The visits per client ratio increased slightly from 1.3 to 1.6 in FY 2020, indicating services must be provided during clients' first visit since clients many do not return for follow-up.

New RFP: In anticipation of the PSS and FP contracts ending on June 30, 2021, the MCHB-WRHS developed an RFP that focused on services for the underinsured and uninsured. A new Request for Information (RFI) and Request for Proposals (RFP) was issued. This RFP aims to increase access to reproductive healthcare and support services for the uninsured and underinsured and encourages enrollment into private or public health insurance. These contracts will be funded with state general funds and will start on July 1, 2021.

ESM 1.1 - Percent of births with less than 18 months spacing between birth and next conception

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Annual Objective		34.0	31.0	31.0	30.0	30.0	30.0	30.0	30.0	30.0
Annual Indicator	32.7	31.7	31.9	30.9	32.4					

The Evidence Based/Informed Strategy Measure (ESM) selected for women's preventive medical visits is the percent of births with less than 18 months spacing out of total births. The measure is related to one of HIMHC goals for preconception and interconception care (women's preventive health) to improve birth spacing through reproductive life planning education and counseling. The FFY 2020 indicator is 32.4% of births met the recommended birth spacing criteria. The data represents a slight increase in births that did not meet spacing recommendations; however, the data is provisional. The 2020 objective (30%) was not met.

Hawaii recognizes the need to revise the ESM from a population-based health outcome to a process measure to monitor progress on the specific strategies and activities. However, this process has been delayed due to COVID and other program priorities. NPM 1 evidence-based research and strategy revisions will be completed in FY 2022 for next year's report.

Current Year Highlights for FY 2021 Sept 2020 - June 2021

Service updates:

- MCHB WHRS continued to provide ongoing Family Planning and Perinatal Support services.
- Systems work through the HMIHC Pre/Inter-Conception Workgroup continued to promote OKQ and address LARC issues.
- All MCHB Family Planning and PSS providers continued providing telehealth and in-person services during the COVID-19 pandemic. MCHB assured contractors followed recommended safety precautions to protect employees and clients.

Title X Update: The relinquishment of Title X grant funds in March 2020, a result of Federal Rule changes under the Trump administration, impacted two areas: state general funds replaced federal funding for family planning services in April 2019 and provider contracts had to be modified. Funding was also reduced and this resulted in less clients receiving family planning services. A reduction-in-force (RIF) occurred in June 2021 due to a loss of federal Title X funding: Secretary II, Public Health Educator IV, and Accountant III. An MCHB reorganization will need to take place in order to accurately reflect operations and the loss of the three positions. The WRHS will continue to monitor changes to the Title X Rules initiated by the Biden Administration and anticipates applying for the Title X grant when the opportunity is announced.

RFP Update: In 2020, the new RFI and RFP were drafted and released for Reproductive Health Care and Support

Services and Related Preventative Health Services with plans to award the RFP in 2021.

Health Equity: The COVID-19 pandemic highlighted the state's health inequities especially among Pacific Islanders, Native Hawaiians, homeless, and low-income families. To address disparities in the health of women of reproductive age, the FY 2022 plans include a new health equity strategy. Activities include acquire and analyze disaggregated data, document existing program efforts to address disparities, and engage community partners/leaders to develop targeted activities to address disparities in women's access to care.

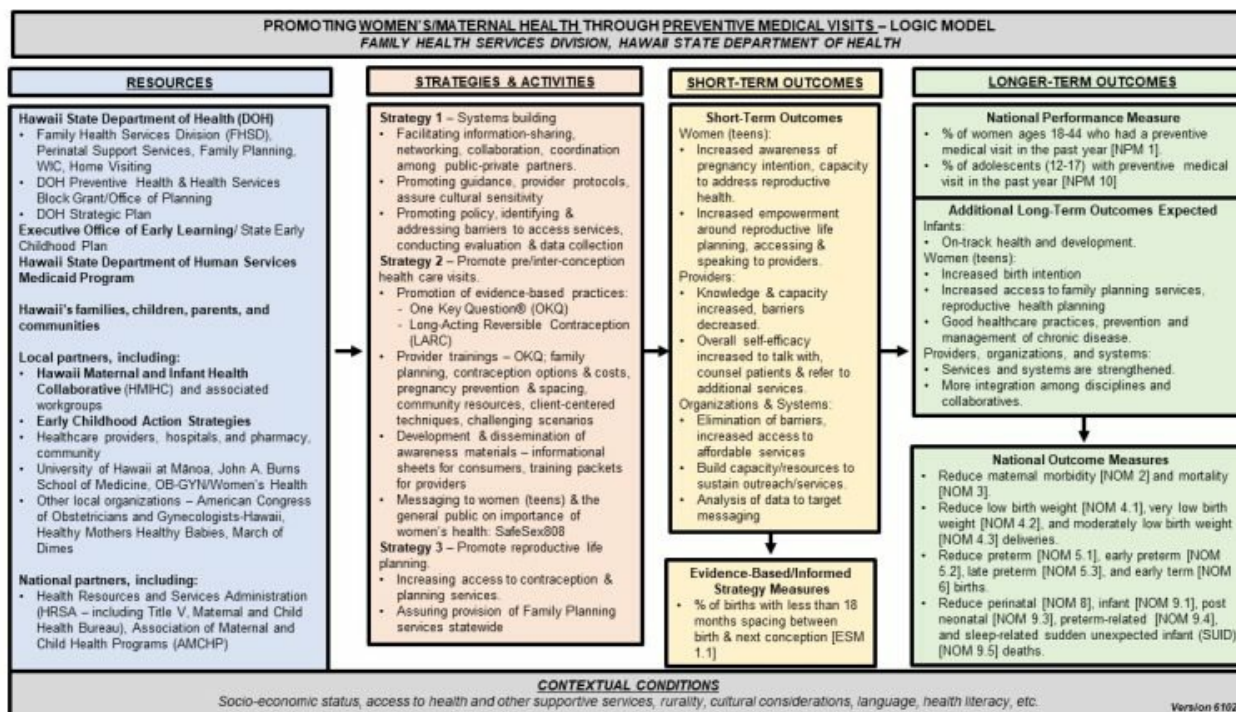
Data Analysis: To address the limited epidemiology capacity, FHSD contracted with the University Office Public Health Studies (OPHS) to access and analyze Hawaii disaggregated data to identify representative racial/ethnic groups that can inform strategies to improve access to preventive women's health services. OPHS will complete a profile of data for women of reproductive age (WRA) highlighting demographics and key health indicators including NPM 1. This includes an informational brief on maternal health with new federal maternal health initiatives, maternal mortality and several maternal morbidity data, and Hawaii program efforts.

Review of the Action Plan

A logic model developed for NPM 1 aligns strategies and activities with performance measures and desired outcomes. The three strategies maximize efforts to attain desired outcomes. The vital work of the HMIHC will continue despite the demands and challenges presented by COVID-19.

Priority Populations: Teens and young adults also continue to be priority populations in need of reproductive health and other preventive services. Coordinated efforts addressing teen health needs and promoting adolescent wellness visits is described in NPM 10 and is included in the logic model.

Health messaging and education efforts for both providers and consumers focuses on OKQ and access to LARC and other family planning methods. Short-term outcomes include increased awareness of pregnancy intention; increased understanding of reproductive health issues; increased empowerment in development of reproductive life plan; and increased self-reliance to access care and speak candidly with providers. For the providers, short term outcomes include increased knowledge, capacity, and effectiveness in counseling clients relating to reproductive health and referral services to community resources. System changes include identification and addressing barriers to access services, development, implementation of sustainable practices and/or protocols, and data management for program evaluation.



The ESM on birth spacing is population based and does not directly measure the impact of the NPM policy and program activities. Hawaii will revise the ESM to a process measure in next year's Title V report.

After review of the 2020 needs assessment data for women's health, the logic model was to be revised to include additional health measures; however, work on this was delayed. Measures include general physical and mental health, obesity, smoking, alcohol use, dental visits, and contraceptive use.

Challenges, Barriers

Some of the ongoing challenges to implementing activities include:

- Loss of significant federal funding for women's family planning services in the state.
- Epidemiology support to acquire and analyze disaggregated Hawaii data not available in the Federally Available Dataset provided by the MCH Bureau.
- Dedicated staff to provide oversight of a statewide OKQ program including developing and implementing the OKQ work plan.
- Need to establish, coordinate, and implement linkages in training needs and ensure data management includes collecting accurate and valid data for OKQ and LARC benchmarks for program evaluation.
- Continued administrative hospital barriers to LARC use such as pharmacy stocking of LARC and private insurance coverage of the device.
- Lack of resources to develop a data management system to establish OKQ and LARC benchmarks, performance measures, and creating a systematic data collection processes.
- Lack of standardized healthcare plan coverage for medical supplies and services across private insurers.

Overall Impact

Over the past five years, Title V has achieved major milestones for the state priority for promote reproductive life planning and women's wellness visits:

- Integration of maternal health into key state plans and collaborative health initiatives allowed for the sharing of

leadership, expertise, and funding.

- Successful partnership building with the formation of the HMIHC with Title V and Medicaid as co-leaders for the Pre/Inter-Conception Workgroup. The diverse members have helped to staff and fund the ongoing work.
- Selection of two key evidence-based strategies focused on the expanding use of OKQ and LARC. Both strategies emerged from the MCH Bureau Infant Mortality CoIN.
- Two Medicaid provider policies to supporting OKQ and Contraceptive Use with information on integrating OKQ into practice; unbundled LARC reimbursement from delivery fees; stocking of LARC devices in birth hospital pharmacies; elimination of prior authorization for contraception; and allowed reimbursement for a year supply of oral contraceptives.
- Over 1000 OKQ trained service providers statewide.
- HMIHC received a National Institute for Reproductive Health (NIRH) Grant to identify and address barriers to Medicaid's expanded LARC coverage policy.
- LARC now stocked in most of the state's largest birthing hospital pharmacies.
- Provision of Family Planning and Perinatal Support Services: over 50,000 client visits over the last five years.
- Maintaining comprehensive and medically accurate reproductive health education and service standards for Hawaii's family planning program despite Trump Administration rule changes.
- Modifying service provider contracts during the COVID pandemic public health emergency to extend the period for funding and allow for flexibility to assure safe telehealth and in-person care.

Women/Maternal Health - Application Year

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

For the Women/Maternal Health domain, NPM 1 Well-Women Visit will continue as a priority based on the results of the 2020 five-year needs assessment. By July 2025, the state seeks to increase the number of women who have a preventive medical visit including pre- and interconception care to 87.0%. Plans to address this objective and NPM are discussed below.

Due to the dramatic operational and personnel changes during the COVID pandemic, many of the activities planned for 2020-21 were delayed, paused, and revised. The timeline for resuming many of these activities remain uncertain at this time. A new health equity strategy has been added to address health disparities highlighted by the pandemic.

Strategy 1: Promoting Women's Wellness Visits through Systems Building

Systems building efforts continue to focus around networking and implementation of activities for these key state plans that include maternal health as a major component. These collaborative efforts include:

- HMIHC Pre/Inter-Conception Workgroup
- Hawaii Early Childhood State Strategic Plan
- Executive Office of Early Learning Action Strategy Plans

Strategy 2: Promote pre/inter-conception health care visits

The HMIHC Pre/Inter-Conception Workgroup plans will continue to focus on expanding use of OKQ and improving access to LARC. In addition, general health messaging for reproductive age women promoting the importance of prevention including medical wellness visits will be developed.

OKQ activities include:

- Continue OKQ training:
 - Conduct clinical and non-clinical OKQ implementation training focusing on private primary care providers
 - Explore provision of OKQ trainings through online or virtual means such as webinars and Zoom
- Develop methods to track, monitor, and evaluate OKQ data across programs and agencies
- Develop and implement a statewide OKQ work plan with a focus in expanding OKQ in new clinical settings statewide. Activities planned include:
 - Complete process mapping the OKQ screening in primary care settings (lead by state Medicaid)
 - Identify training needs for clinical and non-clinical providers
- Develop DOH OKQ work plan that aligns with the HMIHC Pre/Inter-Conception Workgroup plan

LARC activities include:

- Continue to assess and address barriers to implementation of the Medicaid LARC policy at Hawaii's 13 birthing hospitals. JABSOM Department of Obstetrics, Gynecology and Women's Health as part of the NIRH grant and in partnership with Medicaid will continue leading this activity.
- Continue to assess the need for provider training on changes to LARC coverage and codes, placement and removal of devices, and client counseling to increase provider competency.

Strategy 3: Promote reproductive life planning

Title V MCHB will continue work to increase access to reproductive life planning services by providing family planning and perinatal support services to high-risk population. Activities include:

- Identify areas of integration of DOH program services to maximize limited resources and increase efficiency and effectiveness of service delivery (e.g., integrate DOH family planning and PSS to provide seamless transition of clinical services throughout client's reproductive years)
- Continue to require at least annual counseling, education, and development of a reproductive life plan
- Provide trainings on non-directive counseling to ensure providers are meeting clients where they are
- Support telehealth use by reducing barriers to access of care through provision of telehealth TA, resources, and training relating to coding and reimbursement
- Apply for new Title X family planning funding
- Revise the NPM 1 ESM to align with the HMIHC Pre/Inter-Conception Workgroup program evaluation measures

Strategy 4: Promote health equity

Health equity is a priority for all Title V work including women's health. Work in this area will begin with analysis of the Hawaii BRFSS dataset to generate findings that are representative of the state's at-risk populations/communities. The data will be used to engage key community partners.

Initial activities for this new strategy focus on:

- The acquisition of a disaggregated BRFSS survey data to identify Hawaii representative racial/ethnic groups that can inform strategies to improve access to preventive women's health services.
 - The University of Hawaii Office of Public Health Studies (OPHS) will complete a profile of data for women of reproductive age (WRA), highlighting demographics and key health indicators including NPM 1.
 - An informational brief on maternal health including new federal maternal health initiatives, maternal mortality and several maternal morbidity data, and Hawaii program efforts.
 - A short infographic factsheet on Native Hawaiian MCH will also help provide some data and information on maternal health.
- Engage community partners/leaders to develop targeted activities to address disparities in women's access to care.

Title V Women's Health Programs

Women's Health programs administered by Hawaii Title V include:

Women, Infants, and Children: Provides Hawaii residents with nourishing supplemental foods, nutrition education, breastfeeding promotion, and health and social service referrals through the federal program, Special Supplemental Nutrition Program for Women, Infants, and Children. The participants of WIC are either pregnant, breastfeeding, or postpartum women, and infants and children aged under 5 years who meet income guidelines and have a medical or nutritional risk.

Perinatal Support Services: Reduces risk factors that contribute to infant mortality and provides an array of services to address risk factors that lead to poor birth outcomes through contractual services for high-risk pregnant women through pregnancy and six months post-partum.

Family Planning Services: Assists individuals in determining the number and spacing of their children and promotes positive birth outcomes and healthy families. Education, counseling, medical services, and referral as

appropriate are available through state fund. The program provides leadership for the implementation of OKQ – “Would you like to become pregnant in the next year?” OKQ supports reproductive life planning, increases planned pregnancies, and promotes healthy birth outcomes.

Adolescent Health Services: Spans across the physical, mental, and social emotional aspects including sexual health, positive youth development, and transitioning into adulthood for adolescents and young adults ages 10-24 years. The WRHS Adolescent Health Services unit is a recipient of the Personal Responsibility Education Program grant and administers the Evidence-Based Prevention Teen Outreach Program, a program directed toward reducing rates of teenage pregnancy, school failure, and school suspension.

Hawaii Home Visiting: Provides comprehensive early identification of high-risk families, including expectant families and families of newborns who may benefit in home visitation services to reduce health disparities by improving birth, health, and development outcomes through collaboration with and referral from birthing hospitals, physicians, WIC clinics, and community health centers.

Pregnancy Risk Assessment Monitoring System: Identifies and monitors maternal experiences, attitudes, and behaviors from preconception through pregnancy and into the interconception period based on a population-based surveillance system.

Maternal Mortality Review: Reviews causes of maternal deaths occurring during pregnancy up through one year of giving birth to identify public health and clinical interventions, improve systems of care and reduce preventable deaths; team comprises of a multidisciplinary disciplines and multi-agency committees.

Domestic Violence Fatality Review: Conducts multidisciplinary and multi-agency reviews of child, maternal and domestic violence fatalities; near deaths; and suicides to reduce the incidence of preventable deaths in the community. The fatality review process analyzes systems responses to domestic violence with input from community agencies and other related organizations.

Child Death Review: Monitors and performs comprehensive reviews on child deaths for those aged 0-17 years by understanding risk factors of child deaths and reducing preventable deaths of infants, children, and youths. The team comprises of DOH and community partners from multidisciplinary disciplines.

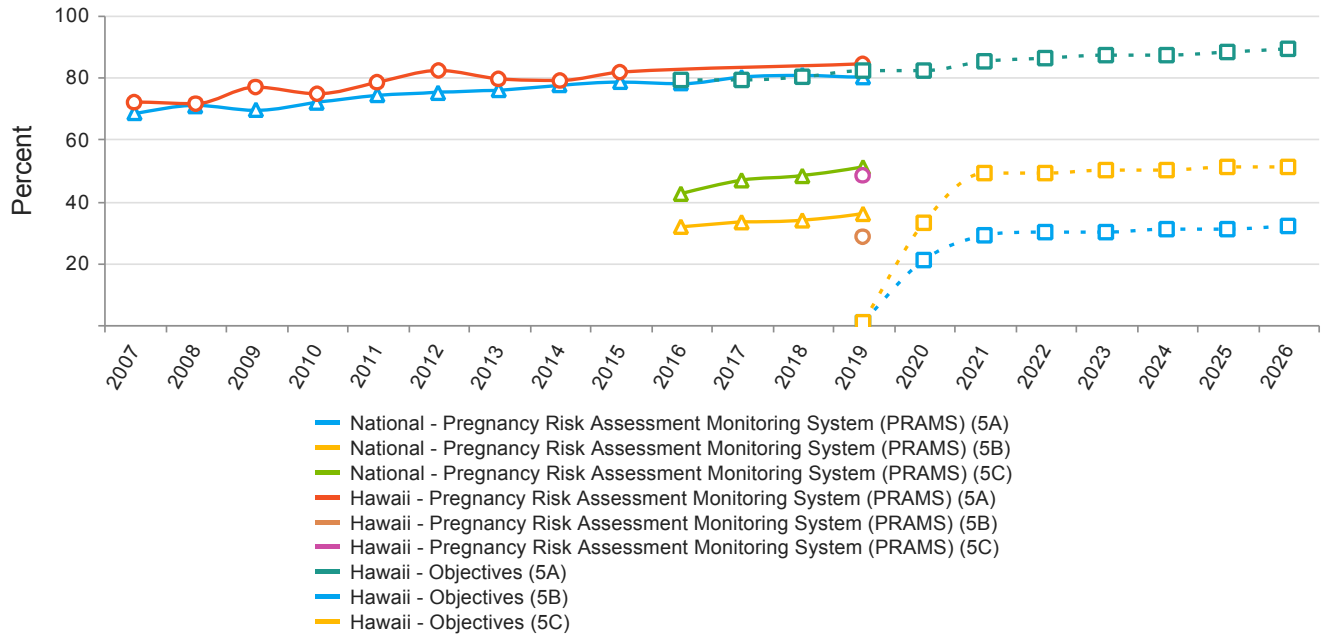
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	6.8	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.9	NPM 4 NPM 5
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	111.9	NPM 4 NPM 5

National Performance Measures

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
Indicators and Annual Objectives



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	2017	2018	2019	2020
Annual Objective	79	79	80	82	82
Annual Indicator	79.2	81.5	81.5	81.5	84.0
Numerator	14,243	14,376	14,376	14,376	6,895
Denominator	17,975	17,634	17,634	17,634	8,212
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2015	2015	2019

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	85.0	86.0	87.0	87.0	88.0	89.0

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2020
Annual Objective	21
Annual Indicator	28.7
Numerator	2,245
Denominator	7,829
Data Source	PRAMS
Data Source Year	2019

State Provided Data				
	2017	2018	2019	2020
Annual Objective			1	21
Annual Indicator	100	100	20.3	28.7
Numerator	1	1	3,306	2,245
Denominator	1	1	16,296	7,829
Data Source	1	1	PRAMS	PRAMS
Data Source Year	1	1	2016	2019
Provisional or Final ?	Provisional	Provisional	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	29.0	30.0	30.0	31.0	31.0	32.0

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2020
Annual Objective	33
Annual Indicator	48.1
Numerator	3,755
Denominator	7,801
Data Source	PRAMS
Data Source Year	2019

State Provided Data				
	2017	2018	2019	2020
Annual Objective			1	33
Annual Indicator	100	100	46.2	48.1
Numerator	1	1	5,186	3,755
Denominator	1	1	11,228	7,801
Data Source	1	1	PRAMS	PRAMS
Data Source Year	1	1	2016	2019
Provisional or Final ?	Provisional	Provisional	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	49.0	49.0	50.0	50.0	51.0	51.0

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - The number of languages in which safe sleep educational materials are available for Hawaii's communities.

Measure Status:			Active
State Provided Data			
	2018	2019	2020
Annual Objective			11
Annual Indicator			0
Numerator			
Denominator			
Data Source			Hawaii Safe Sleep Program
Data Source Year			2020
Provisional or Final ?			Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	11.0	11.0	11.0	11.0	11.0	11.0

State Performance Measures

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) services

Measure Status:		Active
State Provided Data		
	2020	
Annual Objective		
Annual Indicator	25,584	
Numerator		
Denominator		
Data Source	Hawaii WIC Services	
Data Source Year	2020	
Provisional or Final ?	Final	

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	27,000.0	28,000.0	29,000.0	30,000.0	31,000.0

State Action Plan Table

State Action Plan Table (Hawaii) - Perinatal/Infant Health - Entry 1	
Priority Need	
Increase the rate of infants sleeping in safe conditions	
NPM	
NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	
Objectives	
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%	
Strategies	
Increase the membership of Safe Sleep Hawaii through recruitment and identify and engage in opportunities to communicate and collaborate on safe sleep efforts in our state.	
Expand outreach to non-English-speaking families and caregivers through translation of educational materials and safe sleep messages.	
ESMs	Status
ESM 5.1 - The number of languages in which safe sleep educational materials are available for Hawaii's communities.	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

State Action Plan Table (Hawaii) - Perinatal/Infant Health - Entry 2

Priority Need

Reduce food insecurity for pregnant women and infants through WIC program promotion and partnerships

SPM

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) services

Objectives

By 2025, increase the total number of WIC participants in Hawaii to 30,000

Strategies

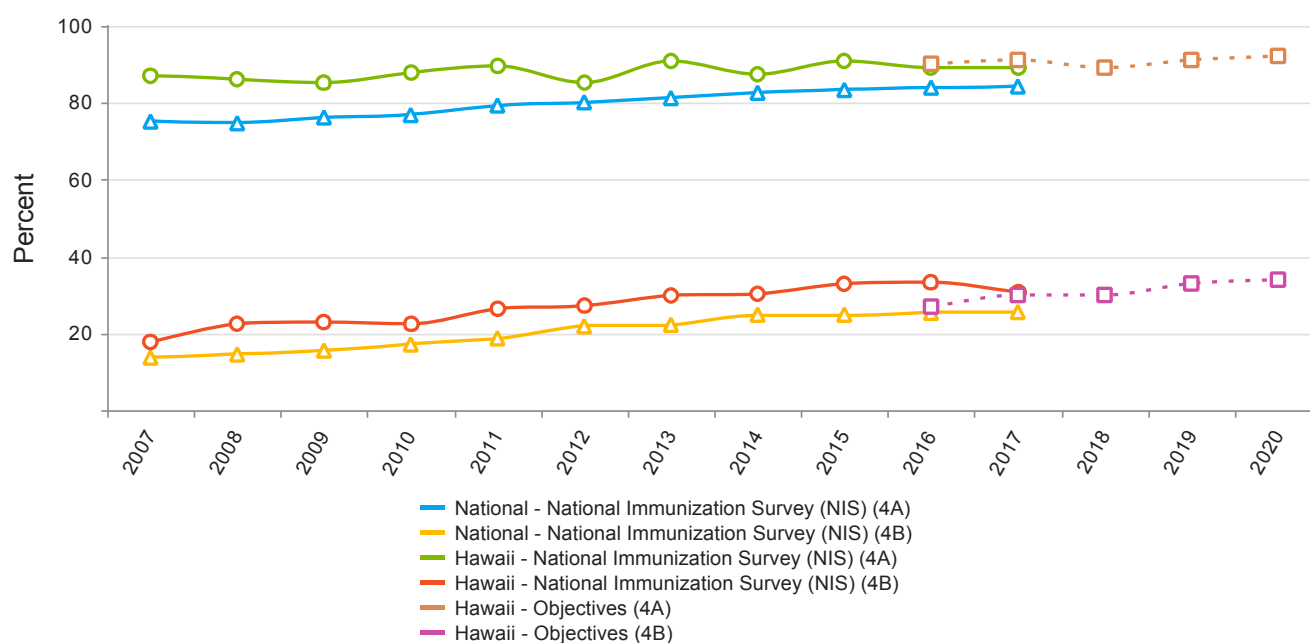
Partner with agency and community programs to establish a working group that is committed to improving WIC utilization

Identify key barriers to WIC benefit utilization and enrollments

Develop recommendations for initiatives to pursue to improve WIC utilization

2016-2020: National Performance Measures

2016-2020: NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months Indicators and Annual Objectives



2016-2020: NPM 4A - Percent of infants who are ever breastfed

Federally Available Data**Data Source: National Immunization Survey (NIS)**

	2016	2017	2018	2019	2020
Annual Objective	90	91	89	91	92
Annual Indicator	90.6	87.3	90.6	88.9	89.1
Numerator	15,214	15,007	15,313	15,129	13,103
Denominator	16,789	17,199	16,911	17,014	14,711
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

2016-2020: NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	2017	2018	2019	2020
Annual Objective	27	30	30	33	34
Annual Indicator	30.1	30.2	32.9	33.2	30.6
Numerator	4,828	5,029	5,396	5,473	4,256
Denominator	16,071	16,662	16,415	16,511	13,927
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

2016-2020: Evidence-Based or –Informed Strategy Measures**2016-2020: ESM 4.1 - Percent of Women, Infants, and Children (WIC) infants ever breastfed**

Measure Status:				Active	
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		81	81	82	83
Annual Indicator	80.6	80.6	80.6	80.6	80.6
Numerator	12,996	12,996	12,996	12,996	12,996
Denominator	16,132	16,132	16,132	16,132	16,132
Data Source	HI WIC Services Program	HI WIC Services Program	HI WIC Services Program	HI WIC Services Program	HI WIC Services Program
Data Source Year	2016	2016	2016	2016	2016
Provisional or Final ?	Final	Final	Final	Final	Final

Perinatal/Infant Health - Annual Report

NPM 5A - Percent of infants placed to sleep on their backs

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Introduction: Safe Sleep

For the Perinatal/Infant Health domain, Hawaii selected NPM 5 based on the results of the 2015 Title V needs assessment. The 2020 Title V state objective for NPM 5A is to increase the percentage of infants placed to sleep on their backs to 82.0%.

Data: The latest data from the 2019 PRAMS survey (84.0%) indicated that Hawaii met the 2020 state objective and the Healthy People 2020 Objective of 75.9% and was similar to the national estimate of 79.9%. There was no PRAMS data collection in Hawaii from 2017 to 2018. PRAMS 2016 data is reported for the 2019 NPM indicator and 2019 PRAMS data is reported for the year 2020. The 2019 dataset includes only 6 months of data.

The increase from the 2016 NPM 5A estimate was not statistically significant. The proportion of infants placed to sleep on their backs has not changed significantly since 2015 (81.5%). Analysis of Hawaii PRAMS 2012-2016 aggregated data revealed Native Hawaiian mothers (72.9%) were less likely to place their infants to sleep on their back compared to Filipino (81.2%), White (85.3%), Chinese (86.3%) and Japanese (88.3%) mothers. Mothers who were under 20 years of age (69.4%) and 20-24 years of age (72.8%) were less likely to place their infants on their back to sleep, compared to mothers who were 25-34 years of age (81.8%) and 35 or more years of age (83.6%). Mothers at or below 100% FPL (76.8%) and those between 101-185% FPL (76.7%) were less likely to place their infants on their back to sleep compared to those at 301% and greater FPL (85.6%).

NPM 5B: The latest data for NPM 5B shows 28.7% of infants were placed to sleep on a separate approved sleep surface, exceeding the state objective of 21% but is significantly below the national percentage (35.9%). There were no significant differences among subgroups based on 2019 data (which may be due to the small 2019 dataset).

NPM 5C: The latest data for NPM 5C indicates 48.1% of infants were placed to sleep without soft objects or loose bedding, exceeding the state objective and is comparable to the national percentage of 50.9%. There were no significant differences among subgroups based on 2019 data.

Objectives: Based on the 2020 needs assessment, this NPM will be continued into the 2021-2025 plan period. Reviewing the baseline data and the HP 2030 objective, the state objectives for all three measures were updated through 2026.

Child Death Review: Despite the small numbers of child deaths in 2019 (141), infant sleeping conditions continue to emerge as possible factors in several Child Death Review (CDR) cases each year.

Title V lead/funding: The supervisor for the Family Strengthening and Violence Prevention (FSVP) Unit under the MCHB serves as the Title V program lead for safe sleep. The FSVP supervisor oversees family violence prevention and parenting support programs. There is no dedicated funding source for Safe Sleep staffing or program activities. Title V-funded staff provide branch-level leadership and overall support for safe sleep program efforts.

Strategies: In 2020, there were three strategies for safe sleep:

- Assure competent workforce through partnerships and training,
- Develop appropriate and consistent parental education and general awareness of safe sleep messages,

- Expand outreach to non-English-speaking families and caregivers through the translation of educational materials and safe sleep messages.

Evidence: A review of the AMCHP and MCH Evidence Center research indicates that targeting caregivers with education is supported by moderate evidence of effectiveness with national campaigns focusing on vulnerable subgroups to have the largest impact in advancing health equity. In 2020 a new strategy was added specifically to address key health disparities in safe sleep behaviors among Hawaii's ethnic groups, focusing on the development of translated educational outreach to non-English-speaking communities. The new strategy was also supported by input from service providers that work with multi-cultural families. ESM 5.2 was created to measure progress on the strategy.

The safe sleep strategies and activities are discussed below.

COVID Impacts: The advent of COVID pandemic shutdown orders and social distancing created enormous disruptions to daily life with school and business closures and travel restrictions that led to profound economic hardships and stress on families. The lockdown restrictions also changed prenatal, delivery, and post-partum services (including family involvement) which may have resulted in less support and information for new parents, putting newborns at risk.

For many families, Hawaii's lack of affordable housing has heightened existing rates of overcrowded households and housing insecurity. Residential overcrowding emerged as a major problem during the pandemic, exacerbating COVID disease transmission. With many families sheltering at home, congestive conditions could have encouraged more co-sleeping with infants, already a common practice in Hawaii.

Through the 2020 pandemic year, safe sleep outreach/education efforts were put on hold for more critical messaging around COVID prevention and essential economic entitlements/supports. These, and other factors may have adversely impacted safe sleep conditions for families with newborns and infants. Infant death and survey data for 2020 data will be closely reviewed when available for trends in safe sleep.

Strategy 1: Assure competent workforce through partnerships & training

This strategy focuses on building partnerships to support information sharing and workforce training for providers that work with families of young children.

Safe Sleep Hawaii (SSH): SSH is the statewide coalition that promotes safe sleep efforts. The group focuses on developing appropriate and consistent parent education materials and general awareness messaging for safe sleep practices, following the current version of the *American Academy of Pediatrics (AAP) Evidence-Based Recommendations for a Safe Infant Sleeping Environment at Birthing Hospitals, Child Care Centers, and Child Care Providers*.



SSH has a diverse membership, with representation from government, non-profit, for-profit, and grass-roots organizations and sectors, as well as families who are committed to preventing infant mortality through safe sleep practices. The quarterly meetings were held in person, but shifted to a video conference format during the COVID19 pandemic. Participation remained relatively stable through the pandemic; however, SSH project work was delayed in 2020 as programs adjusted to many operational changes and responded to dramatic changes in community needs due to COVID.

Staffing Change: Late in June 2020, SSH lead staffing changed from a contracted part-time Registered Nurse to the supervisor for the Family Strengthening and Violence Prevention (FSVP) Unit. The RN coordinated quarterly coalition meetings and activities including: planning the yearly Safe Sleep Summit. State funds were used for the RN contract and the FSVP Supervisor.

Safe Sleep Summit: The annual SSH summit promotes networking, information sharing and conduct trainings. The in-person October 2019 Summit was state-funded by the MCHB. The Summit was attended by 87 participants from around the state, representing public and private agencies. The plenary speaker was Dr. Rachel Moon, an internationally recognized expert in Sudden Infant Death Syndrome (SIDS) and post-neonatal infant mortality. The Summit also featured a panel discussion on infant safe sleep education and breakout sessions focused on practical skills to work with families.

Safe Sleep Policy for Licensed Child Care Facilities: The Department of Human Services (DHS) Child Care Program is a key agency partner in the promotion of safe sleep. The Child Care Program is responsible for the licensing of child care facilities statewide and requires all child care facilities to have a written operational safe sleep policy, review these policies with staff, and undergo annual training on safe sleep practices. SSH assists DHS in developing training materials (including new materials for non-English speaking families), and continues to monitor the implementation of the program. There is emerging evidence to support the effectiveness of mandatory child care provider SS education per the MCH Evidence Center.

Partnering with Title V Early Childhood Programs: SSH resources and materials are shared with the Title V agency programs serving families with newborns and infants, including WIC, Perinatal Support Services, Newborn Screening, Maternal, Infant, and Early Childhood Home Visiting (MIECHV), Parenting Support Services, and Early Intervention Services.

Strategy 2: Develop appropriate and consistent parental education and general awareness safe sleep messages.

This strategy focuses on identifying decision-makers, key partners, and resources to develop safe sleep messages for parents and others who care for infants.

Data to Inform Program Planning/Policy: An Infant Safe Sleep Fact Sheet was developed using data from PRAMS and the Child Death Review (CDR) program and is available on the HI PRAMS website. The fact sheet provides general information on SIDS and Sudden Unexpected Infant Deaths (SUID), data trends, and the importance of infant safe sleep environments. Planned updates to the fact sheet were delayed due to priority COVID issues.

Partnering on Parent/Family Educational Tools: Safe sleep educational materials for families and providers developed with the DHS Child Care program are widely disseminated to many Hawaii programs serving families in birthing hospitals, WIC, Home Visiting, and crib distribution programs. The materials include:

- AAP-recommended guidelines regarding safe sleep environments;
- a letter from a family, “*Don’t let a preventable infant death happen...*”; and
- a poster that can be displayed in the infant’s home, in pediatrician offices, or used as a training tool.

The parent-tested materials are designed to generate dialogues about safe sleep practices with those who care for children, whether family or not.

Promotion of Safe Sleep Environments: Nurse educators who conduct childbirth classes at birthing hospitals statewide provide education to parents about safe sleep environments. The safe sleep posters were used in some

birthing rooms to stress the importance of providing a safe sleep environment for infants. The SSH video featuring family stories about the importance of adhering to safe sleep recommendations is available for hospitals to use on their internal video sites and is also available on the SSH website.

Pack 'n Play Distribution: In May of 2019, the MCHB used state funds for a new crib distribution initiative administered by the Keiki Injury Prevention Coalition (KIPC) called "*KIPC Crib Distribution*." The program includes safe sleep educational information and built on an earlier program, "*Play yards for Keiki*" to support low-income families who were unemployed or receiving government assistance such as Temporary Assistance for Needy Families (TANF). Cribs are distributed through community partners including the YWCA.

Strategy 3: Expand outreach to non-English-speaking families and caregivers through translation of educational materials and safe sleep messages.

Hawaii is a state with a high immigrant and multi-ethnic population, including many English as a second language (ESL) speakers. These populations also bring diverse traditional and cultural practices for infant sleep, including co-sleeping. To expand outreach to these groups, Title V MCHB partnered with the Department of Human Services (DHS) and the Office of Language Access (OLA) to translate the Safe Sleep Guide for Parents into the most common secondary languages spoken in Hawaii households.

The DOH, DHS, and OLA began implementation on the joint venture in 2020 to translate the Safe Sleep Guide for Parents. This workgroup reviewed several sources of data, including Census data, requests for language interpretation services by DHS entitlements programs, and PRAMS data, to help identify cultural groups/languages with an increased risk for sleep-related infant mortality. Through this process, eleven languages were selected for translation: Chuukese, Ilocano, Japanese, Korean, Marshallese, Samoan, Spanish, Simplified Chinese, Tagalog, Traditional Chinese, and Vietnamese.

The Safe Sleep Guide translated text and design layouts were reviewed by focus groups of native speakers to ensure the translations were correct, and information and graphics were appropriately displayed in a readable and understandable manner. The materials were printed in FY 2020. The development of a distribution plan was started in addition to a website and social media campaign. COVID-19 has delayed these activities to FY 2021. Because the materials are not yet broadly available, the ESM 5.2 indicator remains 0.

ESM 5.2 The number of languages Hawaii safe sleep educational materials are currently available for the community

	2019	2020	2021	2022	2023	2024	2025
Annual Objective		11.0	11.0	11.0	11.0	11.0	11.0
Annual Indicator		0					

Current Year Highlights for FY 2021 through June 2021

This section provides highlights of current developmental screening activities for FY 2021. Hawaii continued to convene the SSH coalition through virtual meetings as COVID restrictions continued.

Responding to COVID: With limited SS information and educational outreach efforts occurring through the pandemic in FY 2020, Title V staff and SSH responded by revising the strategies to focus on safe sleep public awareness and continuing work on the dissemination of the translated educational materials. Strategies are:

- Increase the awareness of the importance of Safe Sleep and provide safe sleep education through public

service announcements and digital media

- Expand outreach to non-English-speaking families and caregivers through the dissemination of educational materials and safe sleep messages.

As noted in the introduction, there is moderate evidence for informational campaign strategies. SSH is beginning work of a distribution plan for the translated SS information to agencies and community programs serving families with infants since this work was largely delayed due to COVID-19. The printed safe sleep guides are also being made available electronically on the SSH website, and a social media campaign is being planned.

The 2020 SS Summit Planning Group is revising plans for an in-person conference, given changing gathering and travel restrictions brought about by COVID-19. A state-funded contract is currently pending to help with conference logistics.

Title V staff are working on updating the safe sleep fact sheet with new data and findings on sleep environments and CDR findings. When completed, the information will be used to update safe sleep messages and materials targeting parents and others who care for infants.

Review of the Action Plan

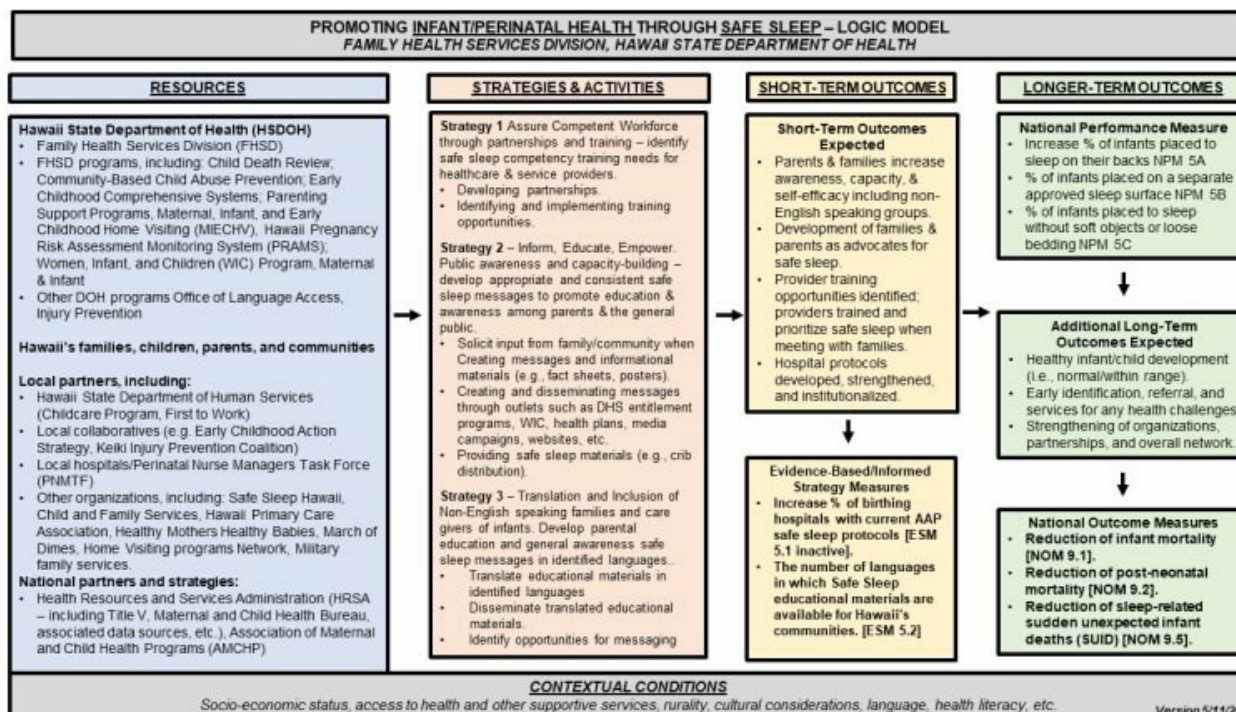
A logic model was developed for NPM 5 to review alignment among the strategies, activities, measures, and desired outcomes. The strategies are:

- Assure competent workforce through partnerships and training
- Develop appropriate and consistent parental education and general awareness safe sleep messages.
- Expand outreach to non-English-speaking families and caregivers through the translation of educational materials and safe sleep messages.

By working on the three strategic areas, Hawaii planned to increase the percentage of infants placed safely to sleep and in safe environments. The activities associated with each of the three strategies directly correlate with short-term outcomes and will impact longer-term outcomes (NPM 5 and NOMs 9.1, 9.2, 9.5). Short term outcomes include:

- Parents and families increase awareness, capacity, and self-efficacy specific to safe infant sleep, including limited and non-English speaking groups.
- Development of public service announcements to be aired on television and other digital media
- Identify provider training opportunities and ensure providers are trained and offer safe sleep information when interacting with families.
- Hospital protocols are developed, strengthened, and institutionalized.

ESM 5.2 measures progress on Strategy 3 to have translated safe sleep information available for Hawaii's diverse ethnic populations.



Challenges Encountered

COVID-19: Safe sleep work was delayed in 2020 as SSH partners and Title V adjusted to many operational changes and responding to new clients/community needs due to COVID. SSH shifted to remote partner meetings. Providers of Safe Sleep education are challenged to rethink service delivery and family engagement, given the ongoing restrictions around birthing hospitals, medical care, and childcare services.

The KIPC crib distribution program required parents to complete an in-person class or meeting but shifted toward virtual learning options. This resulted in delayed outreach to families with newborns. Some families also remain without remote access to reliable internet service or costly devices. The impact of shutdown orders and social distancing remains unclear on family safe sleep practices.

Addressing Co-Sleeping: As the PRAMS data confirmed, co-sleeping is a common practice in Hawaii. Initiatives such as 'Pack and Play' distribution and education through the Cribs for Kids Program have proven effective nationally with high-risk populations. However, addressing local/cultural beliefs and a general acceptance of co-sleeping is challenging. The practice may be attributed to the State's ethnic/cultural diversity, as well as economical constraints related to the State's high cost of housing which contributes to residential overcrowding, housing insecurity, and/or multi-family living arrangements. Data indicate that certain ethnic groups, young mothers, and low-income families are particularly at risk for co-sleeping practices. Working in conjunction with cultural leaders and organizations will be key to the success of targeted outreach to these priority populations. SSH is expanding efforts to include more diverse participation as the multi-lingual messaging is disseminated.

Title V programs: FHSD will continue to engage with other Title V programs (e.g., WIC and Home Visiting), birthing hospitals, FQHCs, DHS benefit programs, as well as other "non-traditional" partners such as pre-schools and churches, to expand educational efforts to a broader audience. With translated materials and social media messaging on safe sleep, SSH will also expand community partnerships to reach broader multi-cultural populations.

Overall Impact

Over the past 5 years, Hawaii experienced a couple major achievements. First, the strategy to have all the state's 12 birthing hospitals adopt safe sleep policies, protocols and guidelines following the AAP standards was completed in 2019. Collaborating with the state Perinatal Nurse Managers Task Force (PNMTF) which includes at least one perinatal nurse manager from each of Hawaii's twelve birthing hospitals, was critical to implementing this strategy ESM 5.1, the "Percent of birthing hospitals with current American Academy of Pediatrics safe sleep protocols" was achieved and retired.

Secondly, in 2018 FHSD worked with the Office of Health Status Monitoring to successfully pass legislation to resume access to vital records data for public health research for PRAMS and Title V reporting. PRAMS data is used for the three Title V breastfeeding measures. For 18 months, PRAMS data collection operations were halted and resumed in December 2018 with approval of data sharing requests from the Department of Health (DOH) Institutional Review Committee. In February 2019, the IRC approved FHSD's access to birth, death, and fetal death dataset (with some restrictions).

Program activities successfully addressed safe sleep through a multi-pronged approach consisting of advocacy, policy development, workforce training, education, supporting safe sleep champions, and grass-roots programs/initiatives. These activities, combined with input from parents and families and the leadership provided by SSH and Title V, were successful in mobilizing Safe Sleep efforts. PRAMS data shows stable safe sleep rates comparable to the U.S. for infant positioning, but the impacts of the pandemic on this measure remain unclear. PRAMS data for 2019 showed some improvement in the use of soft bedding for infants, but Hawaii estimates for separate sleep surfaces remain well below the national rate. More effort is needed to increase awareness, particularly on soft bedding and co-sleeping.

Crib distribution programs that are paired with education help families provide safe sleep conditions, as specified by AAP guidelines are evidence-based. These targeted efforts toward the most vulnerable families have been helpful for families adversely impacted economically by the pandemic.

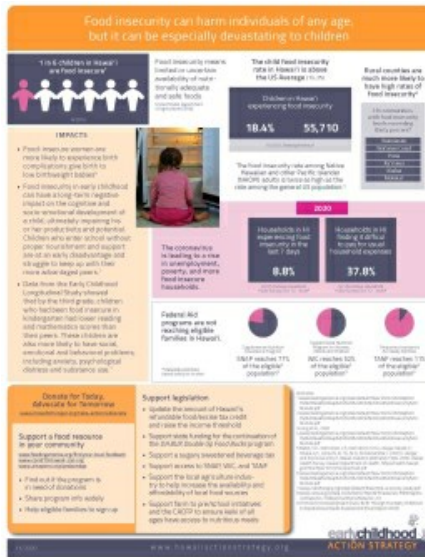
SPM 2 - Number of participants in the WIC program in Hawaii

Introduction: Food Insecurity Priority

For the Perinatal/Infant Health domain, Hawaii added a new state priority to address food insecurity based on the results of ongoing needs assessment and the adverse economic impacts on Hawaii's families due to the COVID-19 pandemic. The focus for this priority will be promotion and utilization of the Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Food Insecurity during Pandemic: The shutdown of the state to tourism and other business closures generated enormous economic consequences for Hawaii's families, resulting in the highest state unemployment in the country through much of 2020. Many families already struggling with Hawaii's high cost of living were suddenly in critical need of assistance with daily essentials. The long lines for food assistance seen nationally were also common in Hawaii, as cars lined up for hours to receive emergency parcels of food.

The Census Bureau Pulse Survey found that food insufficiency in Hawaii households with children [more than doubled](#) between May 2020 (9%) and December 2020 (22%). Hawaii's United Way (UW) hotline also reported a spike in food requests in 2020. Of these requests, [more than half asked for help to feed children](#).



Many service agencies throughout the state rallied to address the immediate needs of families and children. The attention to food insecurity and its impact on young children was reflected in a policy brief released in November 2020 by the Early Childhood Action Strategies network on the dangers of hunger on child development. The brief called on policymakers to expand access to food assistance programs like WIC and the Supplemental Nutrition Assistance Program (SNAP).

In 2021, Hawaii's tourism industry saw a rapid return to pre-pandemic visitor levels as the national economy opened with vaccinations. Forecasts still indicate the state economic recovery will take several years. Food security will remain an ongoing challenge for families. This is confirmed by the Hawaii Foodbank that reported the number of people receiving food donations declined by June 2021; however, demand remained 60% higher than prior to the pandemic.

Expanding the use of WIC and other governmental food support programs is key to helping children and families. A 2020 report by the state's Preschool Development Grant project found both SNAP and WIC could improve its outreach and enrollment to eligible families. SNAP reached 77% of its eligible population, while WIC reached 52% of its eligible families.

The pandemic did significantly increase enrollment in both programs. Between February 2020 and April 2021, participation in Hawaii SNAP increased by 50%, from 126,832 to 190,170 participants when eligibility certifications were temporarily suspended. WIC also saw new enrollments increase by 900 in 2020 to reach nearly 26,000 women, infants, and young children.

Prior to the pandemic, WIC enrollments were showing a steady decline in enrollment since 2016 as the state economy grew. This decline reflected a similar trend nationally in WIC programs. The Hawaii enrollment decline resulted in the closure of several WIC offices and staff RIFs in 2018. The pandemic offers a new opportunity to engage community stakeholders to further support and promote WIC services and enrollments.

Through 2020, family support services mobilized to expand food assistance programs throughout the state. The Hawaii Children's Action Network (HCAN), a Hawaii nonprofit, helped coordinate and disseminate information on family assistance programs including food aid services. Recognizing the value and underutilization of the WIC program, HCAN partnered with WIC to apply for a grant from the Partnership for America's Children (PAC) to help improve promotion of the WIC program. The grant was awarded in May 2021.

Evidence: There is strong evidence to show the WIC program effectiveness. Over more than four decades, researchers have investigated WIC's effects on key measures of child health such as birth weight; infant mortality; diet quality and nutrient intake; initiation and duration of breastfeeding; cognitive development and learning; immunization; use of health services; and childhood anemia. The findings strongly support WIC's demonstrated effectiveness in improving maternal child health outcomes (Center on Budget and Policy Priorities, 2021).

Title V Lead/Funding: The Hawaii WIC Services Branch is the lead program for this food insecurity priority, as the largest public food security program in the nation specifically serving pregnant women with education and support. Although WIC Services are not funded by Title V, WIC does benefit from Title V-funded administrative supports including media, contracting, data analytics, and IT services.

Key Partners: This project is a new partnership between WIC and HCAN, whose mission is to ensure that all children are healthy, safe, and ready to learn. Other partners for this project will include the Appleseed Foundation and University of Hawaii Center on the Family, who will assist with needs assessment and data analysis.

Objective: By 2025, increase the total number of WIC participants in Hawaii to 30,000 pregnant women, infants, and children.

Strategies: Hawaii's three food insecurity strategies are detailed in the PAC grant:

- Partner with agency and community programs to establish a working group that is committed to improving WIC utilization
- Identify key barriers to WIC benefit utilization and enrollments
- Develop recommendations for initiatives to pursue to improve WIC utilization

NPM 4A - Percent of infants who are ever breastfed

NPM 4B - Percent of infants breastfed exclusively through six months

Introduction: Breastfeeding

For the Perinatal/Infant Health domain, Hawaii selected NPM 4 (breastfeeding), based on the results of the 2015 Title V needs assessment. The 2020 Title V state breastfeeding objective is to increase the proportion of infants who are ever breastfed to 92.0%.

Data: The 2020 indicator from the 2017 National Immunization Survey (latest available data) is 89.1%, which failed to meet the annual state objective but met the Healthy People 2020 Objective for breastfeeding (81.9%) and was not statistically different from the national estimate of 84.1%. The current estimate for Hawaii (89.1%) has not changed significantly since 2015 (90.1%).

Based on the 2009-2011 aggregated data, high school graduates were significantly less likely to have infants breastfed (82.4%), compared to college graduates (94.4%). There were no significant differences in reported subgroups by birth order, household income poverty level, marital status, maternal age, gender, and race/ethnicity. For the second breastfeeding NPM, the 2020 Title V state objective is to increase the proportion of infants who are breastfed exclusively through six months, to 34.0%. Data from 2017 showed that Hawaii (30.6%) did not meet the 2020 state objective (34.0%) but was higher than the national estimate of 25.4%. The Healthy People 2020 objective for breastfeeding exclusively through six months (25.5%) was met. The proportion of children breastfed exclusively through six months has not changed significantly since 2015 (32.9%). Higher risk groups were not assessed due to lack of federally available data other than the 2009-2011 aggregate.

Disparities: A review of PRAMS Hawaii data for 2009-2015 indicated Native Hawaiian mothers had one of the lowest rates of breastfeeding to at least eight weeks after delivery, along with mothers 24 years and younger, and those mothers at the lowest federal poverty level.

Breastfeeding has been a priority issue for Hawaii since the 2010 Title V needs assessment. Community stakeholders continue to recognize breastfeeding as a critical practice to improve birth outcomes, reduce infant mortality, and help with health and healing for mothers following childbirth. Hawaii's efforts to improve breastfeeding rates are championed by two important state maternal and child health collaborative entities—the Hawaii Maternal and Infant Health Collaborative (HMIHC) and Early Childhood Action Strategy (ECAS). Hawaii's Title V agency, Family Health Services Division (FHSD), is a key participant in both MCH initiatives.

Breastfeeding Laws: Hawaii has well-established BF workplace laws that prohibit discrimination against BF employees during break time and requirements to provide for workplace accommodation. Women are also permitted to breastfeed their infants in service locations, facilities, and public areas. The challenge now is systematic promotion, enforcement, and monitoring of BF laws and policies.

Title V Lead/Funding: Within FHSD, the Women, Infants, and Children (WIC) Services Branch is the lead program promoting breastfeeding but works collaboratively with other Title V perinatal/infant health programs and community partners. WIC is the largest public breastfeeding promotion program in the nation, providing mothers with education and support. In addition, WIC trains other service providers working with pregnant women and new mothers to promote breastfeeding. WIC also uses breastfeeding peer counselors (BFPCs) to support WIC enrollees at a limited number of clinic locations.

Although Hawaii's overall breastfeeding rates compare relatively well to national averages, studies show lower rates are associated with low-income households, particularly for exclusivity of BF. Strengthening WIC breastfeeding programs provides a key opportunity to assure a healthy start in life for infants and improved health outcomes for post-partum mothers.

Strategies/Evidence: The Hawaii Title V breastfeeding strategies were derived from the 2011 Surgeon General's *Call to Action to Support Breastfeeding* and are generally accepted by Hawaii breastfeeding stakeholder organizations, including Breastfeeding Hawaii; ECAS; HMIHC; Perinatal Action Network; Healthy Mothers, Healthy Babies; and March of Dimes.

The Hawaii strategies include: strengthening peer counseling programs; partnering with community-based organizations to bring WIC breastfeeding services to underserved populations; and collaborating/networking on statewide planning. A review of the AMCHP and MCH Evidence Center research supports Hawaii's strategies: the WIC Peer counseling program and activities such as workforce training of home visiting program staff to promote breastfeeding.

Strategies to address the objectives and NPMs are discussed below.

Strategy 1: Strengthen programs that provide mother-to-mother support and peer counseling.

COVID Impacts on WIC Program: WIC services were adversely affected by COVID with the March 2020 state-mandated stay-at-home emergency orders. Most WIC staff at state clinics and local community organizations moved to telework. All WIC clinics were closed for in-person visits and services for WIC enrollees were provided remotely via phone, mail, and electronic correspondence. Fortunately, Hawaii WIC was in the process of implementing an eWIC (electronic benefits) program in 2020 to replace the issuance of paper checks for food purchase, thereby reducing the need for required in-person clinic visits.

During the pandemic, WIC enrollments also increased by nearly 1,000 new enrollments, reversing a trend of declining enrollment numbers over the past few years.

WIC Breastfeeding Services: One of WIC's core services is to provide breastfeeding education and support to participants. Breastfeeding services include providing guidance, counseling, and breastfeeding educational materials to families before baby arrives; facilitating access to healthy and varied foods; direct engagement with mothers and families to ensure sustained participation in the program; provision of breastfeeding aids such as breast pumps and breast pads; and availability of trained staff and peer counselors to support breastfeeding support and education.

WIC mothers are strongly encouraged to breastfeed their infants unless it is specifically contraindicated for medical reasons. All WIC staff are trained to promote breastfeeding and provide the necessary support that new breastfeeding mothers and their infants need for success. Federal WIC program regulations require state WIC programs to create policies and procedures to ensure breastfeeding support and assistance is provided throughout the prenatal and postpartum period, particularly when the mother is most likely to need assistance.

BFPC: Normally, WIC provides additional services through a Breastfeeding Peer Counseling (BFPC) Program, which conducts monthly group sessions for pregnant and breastfeeding WIC moms to address breastfeeding concerns and provide one-on-one support to those interested. Hawaii WIC uses the U.S. Department of Agriculture's (USDA) *Loving Support*® model, an evidence-based curriculum, to assure the success of the program.

Feedback collected from WIC mothers indicates a high level of satisfaction with the program, particularly the camaraderie shared in the group meetings. The aim of the program is to provide mothers with a trusted friend who has successfully breastfed in the past. Peer Counselors become part of a mother's "Circle of Care," providing breastfeeding information; monthly person-to-person contacts during the pregnancy and postpartum period; and referrals to designated resources when BF support issues fall beyond their scope of knowledge. Four peer counselors currently service seven WIC sites on Oahu. There are no BFPC services on other islands at this time.

COVID Disruptions to Breastfeeding Services: Due to the pandemic, WIC clinics were challenged to provide quality virtual breastfeeding counseling via phone calls, which normally were conducted in person. Group events were cancelled, ending the social bonding and support often praised by program participants. In 2020, BFPCs continued to serve 324 mothers via phone or text. A shortage of sanitizing products also required WIC clinics to suspend all multi-user breast pumps issuance to WIC participants.

Despite these challenges, a review of the 2020 WIC data shows the percentage of six-month duration of breastfeeding increased over the 2019 rate. Anecdotally, WIC staff reported that mothers were opting to breastfeed longer since they were either at home doing more teleworking or unemployed, which was an unexpected positive impact of COVID lockdown statewide.

Text4Baby Messaging: To reinforce breastfeeding promotion and other important health messages, WIC staff continued to refer clients to the Healthy Mothers, Healthy Babies "Text4Baby" service. The service sends enrollees free text messages on prenatal care, baby health, breastfeeding, and parenting tips throughout pregnancy and baby's first year of life.

ESM 4.1 The percent of Women, Infants, and Children (WIC) infants ever breastfed

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Annual Objective		81.0	81.0	82.0	83.0	84.0	85.0	86.0	87.0	
Annual Indicator	80.6	80.6	86.2	85.7	89.1					

In 2020, the percentage of WIC infants ever breastfed increased from 85.7% to 89.1% over 2019.

Strategy 2: Partner with community-based organizations to promote and support WIC breastfeeding services to underserved communities.

WIC partners with several community-based organizations to promote and support breastfeeding. Over the past 15

years, WIC gradually transitioned its service provision from stand-alone, state-operated clinics to contracting WIC services with community-based organizations, such as the Federal Qualified Health Centers (FQHCs). These FQHCs provide an array of services to low-income and underserved populations in at-risk communities, hire staff that reflect the diverse cultural groups found in these communities, and provide more language access resources. WIC offices located in FQHCs are more effective in reaching at-risk WIC clients and providing coordinated MCH services, including breastfeeding support.

WIC also works in conjunction with other Title V programs serving high-risk pregnant women by offering breastfeeding education and training to staff, service contractors, and community partners. These services were largely suspended during 2020 due to the pandemic.

Strategy 3: Collaboration and networking

Hawaii has an active state breastfeeding coalition, Breastfeeding Hawaii (BH), that works to promote, protect, and support breastfeeding through collaboration of community efforts around outreach, legislation, policy enforcement, education, and advocacy. The state WIC breastfeeding coordinator is a board member of BH and serves as a liaison to CDC's Division of Nutrition, Physical Activity and Obesity and the United States Breastfeeding Coalition.

Efforts to improve breastfeeding rates are championed by two important state maternal and child health entities: the Hawaii Maternal and Infant Health Collaborative (HMIHC) and Early Childhood Action Strategy (ECAS). Under the auspices of both organizations, a state breastfeeding plan was developed in 2018 that identified project priorities.



The BF workgroup continued to meet regularly via Zoom in 2020 to implement the breastfeeding priorities and develop messaging to address concerns regarding COVID and breastfeeding. The group members created, translated, and disseminated "Breastfeeding and COVID-19 in Hawai'i," an infographic and resource sheet to encourage mothers to continue breastfeeding safely during the pandemic. The information was used by the DOH Office of Emergency Preparedness to help address questions from the state COVID emergency response network and the public.

The BF workgroup also received a grant to develop breastfeeding toolkits for pediatricians targeting high-risk breastfeeding mothers. The award was made by Papa Ola Lokahi that oversees the Native Hawaiian Health Systems statewide. The toolkit helps pediatric providers offer breastfeeding 'first-aid' in the critical first weeks after delivery and links clients to BF/lactation counselors for follow-up including WIC.

ECAS participants include: Breastfeeding Hawaii; Healthy Mothers, Healthy Babies; March of Dimes; University of Hawaii (UH) Office of Public Health Studies; UH School of Nursing and Dental Hygiene; UH School of Medicine; American Academy of Pediatrics; Kona Community Hospital; Hawaii Public Health Institute; Early Head Start and Head Start; Family Support Hawaii; BAYADA Home Care; La Leche League; Hawaii Mothers Milk; Family Hui Hawaii; FQHCs; and Tripler Army Medical Center.

Current Year Highlights for FY 2021 through April 2021

Here are some highlights of current breastfeeding activities for FY 2021:

- WIC clinics continue to remain closed to in-person services to clients.

- Services continue largely via telephone and text primarily, including BFPC services.
- To enhance the client services/interactions, WIC is working on procuring a secure messaging platform that would be used by all WIC staff, including BFPCs, to include video chat.

WIC continued work to expand the BFPC program to new WIC sites, especially on neighbor islands. A Request for Information (RFI) for BFPC services was held in October 2020. The RFI provided useful details to be added into a formal Request for Proposal (RFP). The RFP will be posted in late 2021 with the intent that state contracts will be executed by the close of the calendar year.

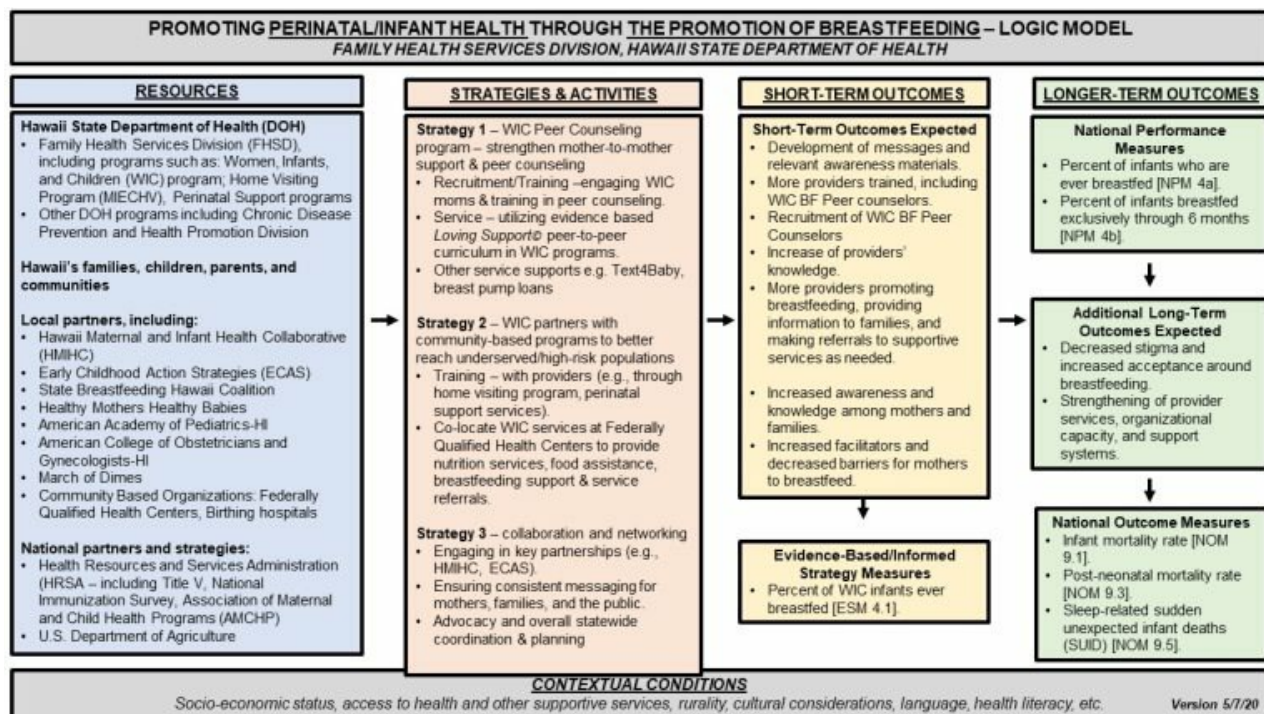
ECAS also received a three-year Robert Wood Johnson award to address the disparities in breastfeeding rates through policy change and community input among Native Hawaiian and Pacific Islander communities in Hawaii. A key partner in the project will be HMSA, the state's largest health insurer. A program coordinator will be supported by the grant funds.

The state Medicaid program sent out messaging to all Medicaid enrollees statewide to encourage WIC enrollment. WIC also partnered with the Hawaii Children's Action Network (HCAN) and other community advocates on a new grant Partnership for America's Children received in April 2021, intended to assess barriers to WIC enrollment and improve promotion of services. A new Title V state priority objective on food insecurity will be the primary focus for the collaborative work on this grant.

Additional messaging was developed on the safety of the COVID vaccine for pregnant women and breastfeeding mothers, utilizing information from the CDC.

Review of Action Plan

A logic model was developed for NPM 4 to review the alignment between the strategies, activities, measures, and desired outcomes. By working on these strategies, the Hawaii Title V program hopes to continue to increase the percentage of infants breastfed.



The strategies address several service levels toward promoting breastfeeding from enabling services to population-based, system-building efforts that impact a mother's 'circle-of-care,' as outlined by the USDA National Breastfeeding Campaign.

Challenges Encountered

It is difficult to assess the immediate and longer-term impacts of the COVID pandemic on pregnant women, infants, and breastfeeding practices given a lag in real time data. However, Hawaii continues to maintain relatively high breastfeeding rates when compared to national estimates/objectives. Initial data from WIC indicates the 2020 COVID shutdown may have enabled more breastfeeding among mothers.

Native Hawaiians continue to comprise over 25% of all births in the state. PRAMS data indicates they are a priority disparity population, with the lowest breastfeeding rates among the state's largest ethnic groups. Partnerships with the Native Hawaiian health systems and RWJ grant funding will target improving these low rates in future years.

WIC will continue to support breastfeeding services, including the BFPC program, despite no in-person services and limited remote engagement for enrollees. More mothers returning to work may adversely impact breastfeeding rates. Prior to the pandemic, WIC data showed the primary reason mothers cited for ending breastfeeding is not having enough milk. Additional data collection is needed to determine if moms' responses are due to true milk insufficiency or due to formula supplementation.

Adoption of family leave mandates may also help a mother's ability to increase her duration and degree of breastfeeding exclusivity. A Paid Family Leave policy has been supported by the current state administration and legislative leadership, but bills have stalled in 2021 due to the pandemic.

Overall Impact

Over the past five years, Hawaii was able to achieve a number of successes for breastfeeding including:

- The establishment and convening of a state breastfeeding workgroup;
- Development of a state breastfeeding plan;
- Completion of a pediatric toolkit to promote BF; and
- COVID-related BF safety messaging.

Working in conjunction with ECAS, the breastfeeding workgroup received two grants to help implement elements of the state plan including targeted strategies to address key health disparities. WIC continues to co-chair the workgroup and support state BF partnership work during COVID.

The FHSD WIC Services Branch breastfeeding promotion program reaches a large high-risk population of pregnant women and young mothers to help promote and support breastfeeding and to help address food insecurity. The Hawaii WIC program serves nearly half the births in the state, making it the largest service provider for this population. Over the past five years, WIC was able to institute a new data system that will generate more detailed breastfeeding data. WIC is also expanding the Breastfeeding Peer Counselor program to the neighbor islands with procurement currently underway for new service providers.

Despite 2020 office closures and reduced in-person contact, WIC state offices and community contractors continue to promote breastfeeding to clients. Although not ideal, the COVID emergency shutdowns resulted in more mothers remaining at home, increasing the percentage of infants receiving exclusive breastfeeding for at least the first six months.

Perinatal/Infant Health - Application Year

NPM 5A - Percent of infants placed to sleep on their backs,

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface,

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding.

For the Perinatal/Infant Health domain, Hawaii selected NPM 5 Safe Sleep, based on the results of the 2020 Title V needs assessment. The 2025 Title V state objective is to increase the proportion of infants placed to sleep on their backs to 86.0%. Objectives were also set for NPMs 5B and 5C. The workplan highlights for the two safe sleep strategies are listed below.

Strategy 1: Increase the awareness of the importance of Safe Sleep and provide safe sleep education through public service announcements and digital media.

The implementation activities for this new strategy include:

- The planning of public service announcements that bring attention to the issue and education of the public on the American Academy of Pediatrics guidelines,
- Working with stakeholders on the development of public service announcements to ensure correct messaging based on American Academy of Pediatrics guidelines for safe sleep,
- Working with parents on feedback of messaging, as well as plans for dissemination,
- Production of safe sleep public service announcements to be run on television and other digital media,
- Strategically airing and providing exposure of public service announcements to at-risk populations,
- Utilizing social media such as but not limited to Facebook, TikTok, and Instagram to promote safe sleep messaging,
- Utilizing websites and the internet to provide safe sleep information and electronic versions of the Safe Sleep Guide for Parents in English and translated languages,
- Directing the public to the social media and websites through the public service announcements for information on safe sleep.

Strategy 2: Expand outreach to Non-English-speaking families and caregivers through translation of educational materials and safe sleep messages.

The implementation activities for this strategy include:

- Work with SSH on a distribution plan to ensure programs and educators in need of translated materials have access including targeted outreach of priority populations/communities through cultural leaders and organizations,
- Work with SSH, State Office of Language Access (OLA), and DHS to identify/develop opportunities for messaging that will reach the identified communities. Messaging outlets may include, but are not limited to, social media, internet, radio, TV, websites, and printed materials,
- Continue to collect and review annual PRAMS data to measure COVID impacts on safe sleep practices,
- Report data for ESM 5.2 to measure progress on this strategy: The number of languages Hawaii safe sleep educational materials are currently available for the community.

SPM 2 – Number of participants in the WIC program in Hawaii

For the Perinatal/Infant domain, Hawaii selected a new state priority and performance measure to address food insecurity issues by promoting WIC services/enrollment, which emerged from ongoing Title V assessment efforts in 2020. By July 2025, WIC participants will increase in Hawaii to 30,000 pregnant women, infants, and children. Plans to address this objective and SPM are from the Partnership for Children grant awarded May 2021. The three strategies and activities are presented below.

Strategy 1: Partner with agency and community programs to establish a working group that is committed to improving WIC utilization

- Engage a diverse, multi-sector WIC working group that includes experts; families that rely on WIC for food support; representatives of racial and ethnic populations that experience high rates of child food insecurity; WIC providers; nonprofits that serve low-income children and families; DOH WIC administrators; and policymakers in the position to facilitate change.
- The group will define membership, select leaders, establish operating guidelines, set a schedule of meetings, and identify goals and objectives.

Strategy 2: Identify key barriers to WIC benefit utilization and enrollments

- The WIC working group will be guided by high quality data analysis, collection of community perspectives, and research into best practices and innovative models in other states that have the potential to succeed in Hawaii.
- The group will examine WIC utilization data desegregated by ethnicity and geography, trends in WIC usage in recent years, Census data, and other sources of information about child food insecurity.
- The group will also identify barriers to accessing services and potential opportunities to improve the intake process. This assessment may include key informant interviews with WIC recipients and WIC providers.

Strategy 3: Develop recommendations for initiatives to pursue to improve WIC utilization

- The WIC working group will research policies and systems in other states across the country that successfully maximize WIC utilization.
- The group will determine potential policy and systems improvements on the state administrative level, as well as initiatives that require legislative approval, in order to develop preliminary policy improvements to be advanced in future years.

NPM 4A - Percent of infants who are ever breastfed

NPM 4B - Percent of infants breastfed exclusively through six months

No plans are reported for NPM 4 because the priority is being deleted in FY 2021 since Hawaii has met both Healthy People 2020 breastfeeding target objectives, and Hawaii rates for these measures remain generally high. The Breastfeeding NPM will be replaced with a new state priority on food insecurity, which has increased during the pandemic. This new initiative will be led by the WIC Services Branch in partnership with the Hawaii Children's Action Network.

Child Health

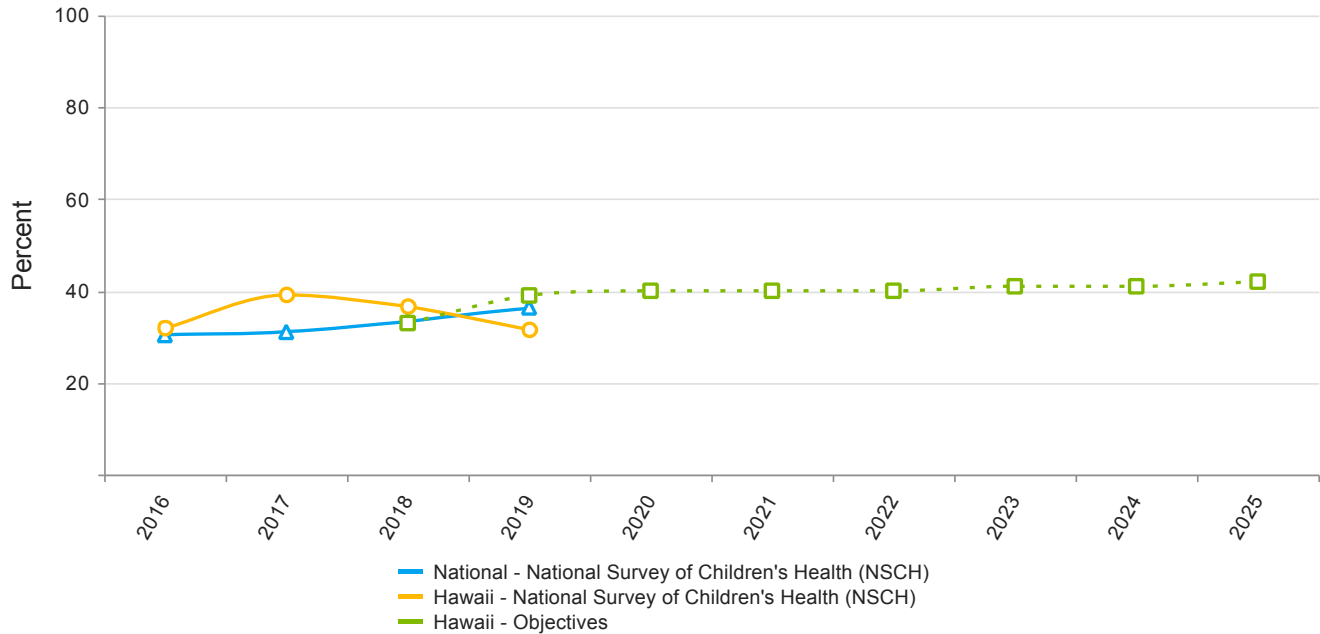
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	12.9 %	NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	18.6 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	92.9 %	NPM 6 NPM 13.2

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Indicators and Annual Objectives



Federally Available Data

Data Source: National Survey of Children's Health (NSCH)

	2016	2017	2018	2019	2020
Annual Objective			33	39	40
Annual Indicator		32.0	39.1	36.5	31.6
Numerator		12,946	14,121	13,201	12,899
Denominator		40,486	36,113	36,145	40,832
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives

	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	40.0	41.0	41.0	42.0	42.0

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - 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

Measure Status:			Active	
State Provided Data				
	2017	2018	2019	2020
Annual Objective			12	18
Annual Indicator				
Numerator	9	19	23	26
Denominator	30	30	30	30
Data Source	Early Childhood Coordinator	Early Childhood Coordinator	Early Childhood Coordinator	Early Childhood Coordinator
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	24.0	27.0	30.0	30.0	30.0	30.0

State Performance Measures

SPM 1 - Rate of confirmed child abuse and neglect reports per 1,000 for children ages 0 to 5 years.

Measure Status:			Active	
State Provided Data				
	2017	2018	2019	2020
Annual Objective			5.9	5.5
Annual Indicator		5.9	5.5	5.7
Numerator		635	584	591
Denominator		108,119	105,815	104,141
Data Source		DHS CAN annual report	DHS CAN annual report	DHS CAN annual report
Data Source Year		2017	2018	2019
Provisional or Final ?		Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.4	5.4	5.3	5.3	5.2	5.2

SPM 5 - The percentage of Medicaid children receiving six or more well-child visits in the first 15 months of life

Measure Status:		Active
State Provided Data		
	2020	
Annual Objective		
Annual Indicator	72	
Numerator		
Denominator		
Data Source	Hawaii Med-QUEST	
Data Source Year	2019	
Provisional or Final ?	Final	

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	81.0	84.0	87.0	90.0	93.0

State Action Plan Table

State Action Plan Table (Hawaii) - Child Health - Entry 1

Priority Need

Improve the percentage of children screened early and continuously ages 0-5 years for developmental delay

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

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 45.0%

Strategies

Systems Development

Family Engagement and Public Awareness

Data Collection and Integration

Social Determinants of Health and Vulnerable Populations

Policy and Public Health Coordination

ESMs

Status

ESM 6.1 - 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

Active

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Hawaii) - Child Health - Entry 2

Priority Need

Reduce the rate of confirmed child abuse and neglect cases per 1,000 with special attention to children ages 0-5 years.

SPM

SPM 1 - Rate of confirmed child abuse and neglect reports per 1,000 for children ages 0 to 5 years.

Objectives

By July 2025, reduce the rate of confirmed child abuse and neglect cases per 1,000 for children to 5.2 per 1,000

Strategies

Collaborate on and integrate child wellness and family strengthening activities across programs.

Raise awareness about the importance of safe and nurturing relationships to prevent child abuse and neglect.

Provide community-based training and technical assistance promoting safe, healthy, and respectful relationships to prevent child abuse and neglect.

Collaborate with the Hawaii Department of Human Services Family First Prevention Services Act primary prevention initiatives.

State Action Plan Table (Hawaii) - Child Health - Entry 3

Priority Need

Promote child wellness visits and immunizations among young children ages 0-5 years.

SPM

SPM 5 - The percentage of Medicaid children receiving six or more well-child visits in the first 15 months of life

Objectives

By July 2025, increase the percentage of Medicaid children receiving six or more well-child visits in the first 15 months of life

Strategies

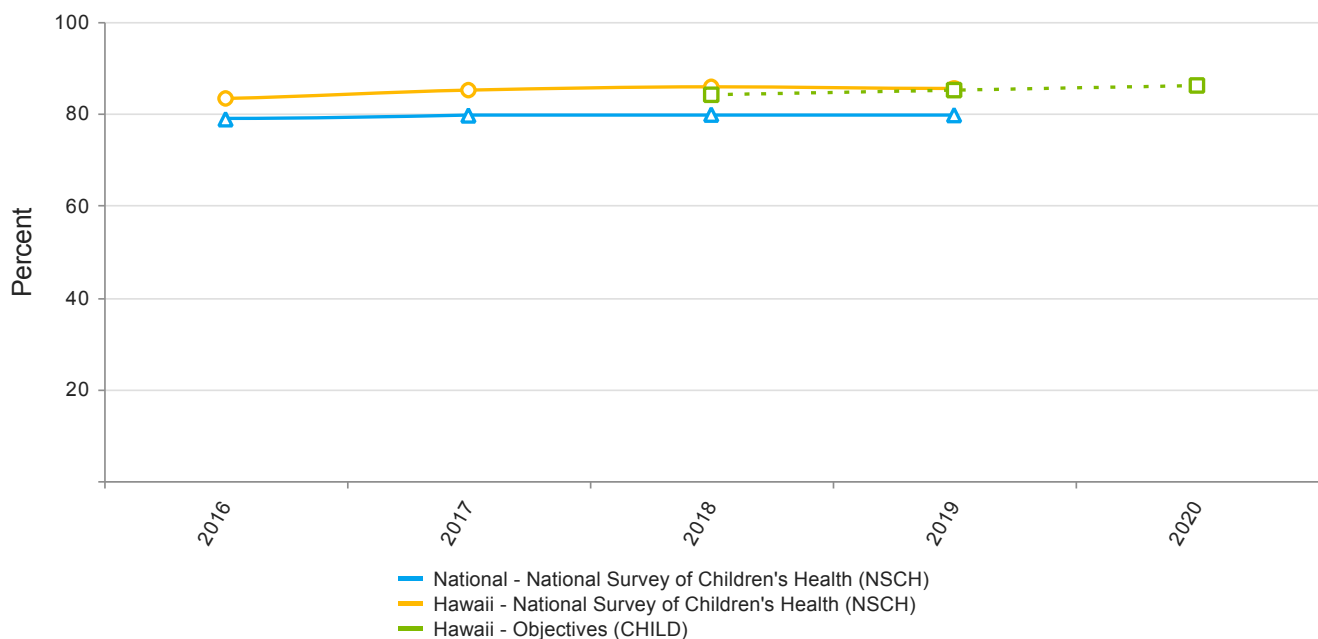
Collaborate with pediatric providers and community advocates to promote messaging on importance of well-child visits.

Conduct public awareness campaign and measure effectiveness of messaging (increase number of visits to the doctor, increase # of vaccinations for the home visiting population).

Build capacity for developing pediatric champions to promote messaging campaign.

2016-2020: National Performance Measures


2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year Indicators and Annual Objectives



2016-2020: NPM 13.2 - Child Health

Federally Available Data**Data Source: National Survey of Children's Health (NSCH)**

	2016	2017	2018	2019	2020
Annual Objective			84	85	86
Annual Indicator		83.1	84.9	85.6	85.5
Numerator		243,681	242,790	234,467	239,545
Denominator		293,312	285,950	273,914	280,315
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

 Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

2016-2020: Evidence-Based or –Informed Strategy Measures**2016-2020: ESM 13.2.3 - The number of organizations and individuals participating in State Oral Health Coalition meetings and activities**

Measure Status:		Active	
State Provided Data			
	2018	2019	2020
Annual Objective			60
Annual Indicator	48	64	64
Numerator			
Denominator			
Data Source	Hawaii Oral Health Coalition	Hawaii Oral Health Coalition	Hawaii Oral Health Coalition
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

NPM 6 - Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed screening tool

Introduction: Developmental Screening

For the Child Health domain, Hawaii selected NPM 6 Developmental Screening as a priority based on the 2015 five-year needs assessment. By July 2020, the state sought to increase the proportion of children, ages 9 through 35 months, receiving a developmental screening, to 40.0%.

Data: Aggregated data from 2018-2019 showed the estimate for Hawaii (31.6%) did not meet the 2020 state objective (40.0%) but was not significantly different from the national estimate of 36.4%. Although the data appears to show Hawaii's rate of screenings are decreasing over the past three years, *none of the differences are significant*. Due to the small sample size, results for this measure should be used with caution. The related Healthy People 2020 Objective for developmental screening (24.9%) was met. There were no significant differences in reported subgroups by health insurance, household income; but again, this may be due to the small sample size.

Objectives: Based on the 2020 needs assessment, this NPM will be continued into the 2021-2025 plan period. Because of the sample size of the data for NPM 12, it is unclear whether the data truly reflects a decrease in screening since the differences in the data over the past five years are not statistically significant. Reviewing the baseline data and the HP 2030 objective, the state objectives through 2026 were updated to reflect an annual increase of one percentage point.

Title V Lead/Funding: Developmental screening has remained a continuing priority since 2010 for Family Health Services Division (FHSD), which coordinates federal, state, and local efforts on screening, referrals, and services. The leads are the Children with Special Health Needs Branch (CSHNB) Early Childhood Coordinator and the Early Childhood Comprehensive Systems Impact (ECCS Impact) Grant Coordinator. The ECCS Impact grant funds the grant coordinator position and activities. The CSHNB Early Childhood Coordinator is a state-funded position. Title V does not directly fund development screening program staff and activities but does support management, epidemiology, data, and administrative positions that contribute to the NPM.

Title V convenes a Developmental Screening Workgroup comprised of FHSD early childhood programs, including:

- Hi'i lei Hawaii Developmental Screening Program – offers on-line or paper copies of the Ages and Stages Questionnaire:3 (ASQ:3) for families of children birth through five years.
- Home Visiting Services Unit – funded by the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant. Its home visitors work with parents to complete the ASQ.
- Newborn Hearing Screening Program – oversees the Early Hearing Detection and Intervention data system for hearing screening of children birth to age 3.
- Early Intervention Section (Hawaii's IDEA Part C agency) – provides services and supports for children birth to age three who have a developmental concern.
- ECCS Impact Grant – focuses on developmental screening of children birth through five years for Maui County.
- FHSD Programs within the District Health Offices from Hawaii Island, Maui, and Kauai.

Partnerships: There is broad collaboration among statewide agencies and stakeholders working toward a statewide systematic approach to developmental screening, including medical partners, early childhood providers, and community-based nonprofits who conduct developmental screening and ensure children are connected to services or supports if a concern is identified. Development screening is also identified as a priority in several key state

plans, including:

- Executive Office on Early Learning's Early Childhood State Plan for 2019-2024;
- Preschool Development Grant (PDG) Birth through Five Strategic Plan; and
- Early Childhood Action Strategy (ECAS), a nonprofit public-private partnership, focusing on children's issues prenatal through age eight.

Nationally, developmental screening is promoted through grants and guidance documents, including:

- HRSA ECCS Impact Grant that emphasizes partnership with healthcare and early childhood care/education providers to promote developmental screening;
- American Academy of Pediatrics (AAP) policy statement that recommends screening using a validated tool at 9, 18, 24 or 30 months as part of a well-child visit; and
- Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. In Hawaii, Medicaid is administered by the State Department of Human Services (DHS) Med-QUEST Division (MQD).

Strategies/Evidence: Hawaii's five developmental screening strategies focus on systems-level approaches and follow guidance from three sources:

- Federal ECCS Impact Grant,
- HRSA's Title V "State Technical Assistance Meeting" in March 2016, and
- National MCH Evidence Center.

The five strategies are:

- Build systems and infrastructure
- Implement family engagement and public awareness activities
- Ensure data collection and integration
- Address social determinants of health and vulnerable populations
- Assess policy and public health coordination

The last strategy is assessed via a Policy and Public Health Coordination Scale (PPHC) designed to monitor implementation of the systems-level approaches and is used as the NPM 6 strategy measure (ESM 6.2).

The HRSA ECCS Impact best practices promote working with early childhood providers to ensure that screenings are done as part of their assessment of children's development and supported by:

- National Association for the Education of Young Children (NAEYC) Accreditation
- Head Start Performance Standards
- National Institute of Early Education Research benchmarks for early education programs

Hawaii works with these programs to ensure the national standards are implemented.

Research compiled by AMCHP and the MCH Evidence Center indicate evidence-based support for training of healthcare providers on developmental screening and screening through home visiting programs, although further evidence is needed. Following these promising practices, Hawaii provides community-based trainings on the ASQ:3 to both healthcare and early childhood providers. Although quality improvements in both healthcare settings and systems-level approaches were found to be effective, Hawaii's Title V agency does not have direct control over healthcare settings and therefore chose a general systems approach to continue quality improvement practices. The Evidence Center indicated Hawaii's ESM 6.2 to have 'moderate evidence' related to QI activities.

Updates for 2020 on the five strategies follow.

COVID Impacts: Because of COVID-19, many programs closed to in-person visits and screenings with the governor's mandatory stay-at-home orders that went into effect in March 2020. Most residents were asked to remain home and leave for only essential goods and services. With the closures, some childcare programs and most schools stopped in-person learning and moved to online learning. Initially, many doctor's office closed temporarily to implement ever-evolving safety protocols and secure critical PPE. In addition, parents' fears of COVID-19 exposure resulted in appointment cancellations or delays. These factors contributed to the likely decrease in developmental screenings in 2020. The on-going impact of the pandemic and the severe economic impact on families shifted priorities to ensuring basic needs (housing, food security, employment, and income), taking precedence over monitoring their child's development. Many programs and services pivoted to address the critical impacts of COVID-19.

Strategy 1: Systems Development – Develop infrastructure to coordinate developmental screening efforts

The activities for this strategy focus on systems and policy development to support children's developmental screening. Hawaii depends on its partnerships in the healthcare, early childhood communities and parent advocacy organizations to assist with the four stages of developmental screening: screenings, referrals, services and supports, and family engagement.

Guidelines on Screening and Referral: "Hawaii Developmental Screening and Referral Guidelines for Early Childhood and Community Based Providers" are available to provide standard information for those conducting developmental screening of children ages birth through five years of age. They are based on the following national resources:

- AAP Policy on Developmental Surveillance and Screening Guidelines;
- Centers for Disease Control and Prevention (CDC) Act Early Campaign;
- Bright Futures: Guidelines for Infants, Children, Adolescents Health; and
- National standards from the Resource Center for Health and Safety in Child Care and Early Education (NRC), Head Start Program, and NAEYC.

The guidelines also include local best practices and were vetted with early childhood and medical providers and other key stakeholders. Because of the pandemic and the shift to connecting with families remotely, the guidelines were revisited in conjunction with stakeholders to ensure the information was relevant, whether screenings were conducted in person or virtually. This document can be found on the Department of Health website:

<https://health.hawaii.gov/cshcn/hiileihawaii/>.

Workforce Training: Before the pandemic, Hawaii had planned to conduct trainings for early childhood programs on the Stages Questionnaire 3 (ASQ-3) and Ages and Stages Questionnaire Social Emotional -2 (ASQ:SE2) throughout FY 2020. A few trainings were conducted in the fall of 2019 but trainings since March 2020 have been placed on hold.

CSHNB was able to partner with Project ECHO Hawaii, which provided a virtual platform to conduct educational webinars to healthcare providers on Developmental Screening and the services provided by Early Intervention Section (EIS). Two webinars were completed in May and June 2020 to audiences of approximately 30 participants each from across the state. The CDC Act Early Ambassador for Hawaii and CSHNB Early Childhood Coordinator presented on the different screening tools and the referral processes for children identified with a developmental concern.

The DOH Early Intervention Section conducted an ECHO webinar on their Primary Service Provider model and the referral process for children who may be identified as having a developmental concern. The webinars are archived on the ECHO Hawaii website as a training resource for providers.

Strategy 2: Family Engagement & Public Awareness

The activities for this strategy focus on engagement with families to promote understanding of the importance of developmental screening and child development. COVID restrictions resulted in many childcare program closures and other family support programs shifting to online platforms, increasing family stress exponentially. Families struggled with sudden job/income loss, while also assuming responsibility for the care and education of their children. This raised concerns regarding increased substance use, family violence, and mental health concerns exacerbated by social isolation imposed by the pandemic. While promoting child development remained a priority, service providers focused on public awareness and messaging on self-care and the importance of seeking help when needed.

Outreach to Families: Many family organizations moved to online platforms and conducted virtual family support group meetings to connect families. One parent group, Leadership in Disabilities and Achievement of Hawaii (LDAH), conducted parent groups using Facebook Live. CSHNB was asked to share information about its programs with families. Information about Hi'iilei Developmental Screening Program, which promotes the online or paper version of the ASQ screening tool for parents, was highlighted. On Maui, the ECCS Impact Coordinator also engaged families with Facebook Live groups. Families were enlisted through partner organizations and shared their experiences on child development and other concerns during the pandemic. Socio-emotional kits were created and distributed to families through pediatricians' offices. These kits promoted family activities and also personal parental well-being. Hi'iilei Hawaii worked with the local cable television to develop a one-minute public service announcement on developmental screening, which is posted on the DOH website: <https://health.hawaii.gov/cshcn/hiilei/>.

Screening Information Websites: Hawaii continues to work with the Early Childhood Action Strategy (ECAS), a public-private collaborative that focuses on children's issues prenatal through age eight. The CSHNB Early Childhood Coordinator leads the ECAS On-Track Health and Development Team. Documents on screening are housed on the ECAS website, which provides information about child development (<https://hawaiiactionstrategy.org/>). The DOH CSHNB website houses developmental screening information on its website: <https://health.hawaii.gov/cshcn/aboutus/>.

Strategy 3: Data Collection and Integration

The activities for this strategy focus on acquiring population-based developmental screening data to monitor needs and identify vulnerable at-risk populations and communities. At this time, there is little timely 2020 data available to assess the pandemic impact on screening rates. However, FHSD and other direct service programs for children and families did see a decrease in client services during the pandemic. MIECHV reported many of their families postponed well-child visits and delayed immunizations due to COVID. Program referrals to EIS and Preschool Special Education also saw declines. Generally, preventive services and screenings decreased during the pandemic, reflecting national trends. It's likely developmental screening rates also decreased.

National Survey on Children's Health (NSCH) data: The latest NSCH data for this NPM is for 2019, thus does not reflect the impact of the pandemic. In addition, there are several issues with the NSCH data that limits its utility to inform planning and address health equity. While the survey provides standard state-level estimates, the data reported for this measure is small and unreliable to determine trends or identify significant Hawaii ethnic disparities

to assist in developing effective prevention and treatment strategies. Also, county-level data is not available to help target geographic efforts. The racial/ethnicity data collected by the NSCH are not representative of Hawaii's majority Asian, Native Hawaiian, and Pacific Islander population. FHSD has explored survey oversampling for several years with the MCH Bureau, but the cost and administrative procurement barriers are prohibitive. Lastly, the NSCH survey question asks parents about screenings that occur only in a healthcare provider's office; however, developmental screening efforts include work with early childhood providers.

Medicaid: Currently, the Hawaii Medicaid Program (MedQuest-DHS) does not report on Developmental Screening rates for up to age 3, one of the CMS core children's healthcare quality measures. Only 28 states report on this optional measure. The only reported Medicaid screening data is from the "Form CMS-416: Annual EPSDT Participation Report." However, the EPSDT data really reflects medical visits vs. actual screenings. The data for this form also lags by nine-12 months.

While healthcare providers may document developmental screening information in client records, it is unclear to what extent health insurers are collecting and using the aggregated data for performance or quality improvements. Also, healthcare providers may not use validated screening tools but may instead exercise the option to use their clinical judgment or observation to identify concerns. Although health insurance coverage is relatively high in Hawaii, families may experience obstacles to scheduling well-child visits and miss the recommended developmental screenings.

Service information for early childhood programs may be a potential data source, but the same lack of infrastructure to aggregate and analyze the screening data from individual service providers is a barrier. For instance, the State Department of Human Services (DHS) Child Care Program requires all parents/caregivers at licensed child care programs to report developmental screening and other health data for each child. However, none of this data is reported to DHS and is kept on file by the childcare provider.

Title V Program Data: Developmental screening data is collected and reviewed for quality assurance and monitoring from FHSD's early childhood programs: MIECHV, ECCS Impact Grant, Hi'ilei, and Early Intervention. Data is currently available for 2020.

Data from the MIECHV Home Visiting program for FFY 2020 showed that 75.8% of the 561 children enrolled in the program were screened for developmental delay. Of those children with positive screens for developmental delays, 71% of children received services in a timely manner. Hawaii's home visiting program screens follow the AAP guidance.

The Hi'ilei Developmental Screening Program provides parents and caregivers an option of completing an online screening or completing a paper copy of the developmental screener through the mail. FFY 2020 Hi'ilei data shows that 44 children birth through 5 years were screened. Seven of the children were found to be in the "monitoring" range. None of the children were found to be in the referral range and information on activities to support their children's optimal development were provided to the parent.

Hawaii's ECCS Impact grant collects developmental screening data from two major childcare providers serving Maui County, an Early Head Start program and a Family Child Interaction Learning Program. In 2020, two screens were added, at 40-months and 42-months, in addition to the 36-month screens for 3-year-olds. This resulted in a substantial increase in the number for screens in 2020 (470). Only a few cases required follow up and were connected to services as needed. The ECCS Impact Coordinator hosts bi-monthly community meetings to discuss the data from the ECCS project, including the number of children screened from within the referral range and number referred and connected to services.

Referrals to Early Intervention (EI) come from various sources. FFY 2020 shows that 2,753 children were referred, with 58% of referrals coming from Primary Care Providers, 25% from families, 31% from community providers, 0.5% from Resource Caregivers, and 1.9% from child welfare. Programs providing referrals include childcare, home visiting, public health nursing, Early Head Start, and healthcare or social service providers. Referrals to EI were down from 2019 (3,260), which may be attributed to COVID-19 closures. Of the 1,954 evaluations that were conducted, the majority of the referrals were found eligible, with close to 90% of those referred receiving services. Only 176 were found ineligible.

Developing a coordinated data system for FHSD and the state around screenings and referrals was hindered by the different time frames in which data are collected, and the different ages at which children are screened.

Strategy 4: Social Determinants of Health

The activities for this strategy focus on working with partners to identify vulnerable populations and assure programs exist to provide developmental screening services and follow-up to these communities. The COVID pandemic rapidly expanded the population needs in the state, including access to healthcare. Many families lost affordable employee-based healthcare insurance, resulting in a dramatic increase in Medicaid enrollments. The pandemic also highlighted existing health disparities and inequitable access to broadband internet and devices to utilize online, telehealth, and educational services.

Prior to the pandemic, the CSHNB Early Childhood Coordinator planned to pilot a development screening program at the state's largest emergency shelter system, the Institute for Human Services (IHS), which helps children and families to find stable housing, employment, and address other critical needs. The project was put on hold because of the COVID-19 pandemic. Another pilot project to conduct developmental screenings in WIC clinic waiting rooms on the neighbor islands was initiated but disrupted by COVID closures.

The 2020 needs assessment completed for the state's federal Preschool Development Grant identified rural and neighbor island communities with the greatest needs for healthcare and information about child development since medical and specialty services are concentrated in urban Honolulu. The focus of the current ECCS Impact Grant on Maui County helped to address some of this need. FHSD Neighbor Island RN Coordinators work to promote development screening in conjunction with the CSHNB program and community partners; however, the FHSD Neighbor Island nurses were deployed throughout 2020 to assist with COVID testing, outreach, and contact tracing.

Strategy 5: Policy and Public Health Coordination

The purpose of this strategy is to track FHSD's infrastructure development efforts to improve developmental screening rates of children.

ESM 6.2 – Develop and implement Policy and Public Health Coordination rating scale to monitor developmental screening efforts around the areas of systems development, family engagement, data collection/integration, and addressing vulnerable populations.

	2018	2019	2020	2021	2022	2023	2024	2025
Annual Objective		12.0	18.0	24.0	27.0	30.0	30.0	30.0
Annual Indicator		23.0	26.0					

ESM 6.2 Policy and Public Health Coordination Scale

Hawaii developed a Policy and Public Health Coordination Scale (PPHC) to monitor progress on Title V efforts to improve developmental screening rates of children. The scale (below) reflects the activities in the NPM 6 logic model and workplan, including Systems Development, Family Engagement and Messaging, Data Collection/Integration, Addressing Social Determinants, and Policy and Public Health Coordination. Completion of the scale is self-reported by the EC Coordinator who oversees all the activities.

The total possible points for the scale are 30. The FY 2020 indicator was 26 and met the annual objective set at 12. Despite the pandemic, progress was made in systems development, family engagement, and addressing vulnerable populations. The rating scale is used by the EC Coordinator to track progress on the NPM 6 strategies even prior to its formal adoption as an ESM last year. Scores show an improvement from last year's score of 23 with room for improvement in the family engagement and social determinants of health identification and work with stakeholders.

Element	0 Not Met	1 Partially Met	2 Mostly Met	3 Completely Met
Systems Development				
1. Develop guidelines and toolkit for screening, referral, and services.				x
2. Work with partners to develop infrastructure for ongoing training, technical assistance, and support for providers conducting developmental screening activities.			x	
Family Engagement and Public Awareness				
3. Work with families and parent organizations to develop family-friendly material explaining importance of developmental screening and how to access services.			x	
4. Develop website to house materials, information, and resources on developmental screening.				x
Data Collection and Integration				
5. Develop data system for internal tracking and monitoring of screening, referral, and services data.				x
6. Develop process for on-going communication to review data findings and adjust for better outcomes for children and families.				x
Social Determinants of Health and Vulnerable Populations				
7. Develop process for identifying vulnerable populations.			x	
8. Work with stakeholders to address supports and targeted interventions for vulnerable populations.			x	
Policy and Public Health Coordination				
9. Develop Policy and Public Health Coordination Rating Scale.				x
10. Conduct process for annual assessment of rating scale.				x
Total Score	26 out of 30			

The Title V agency work to strengthen its ESMs by shifting from process to outcome impacts/measurements was postponed due to the pandemic.

Current Year Highlights for FY 2021 through June 2021

This section provides highlights of current developmental screening activities for FY 2021.

Hawaii continued to work with the ECCS Impact grant and other partners through virtual meetings. Access to online developmental screening through Hi'ilei has become a vital option for parents who are not physically taking their child to see their pediatrician for well-child visits or for families who have concerns about their child's development. However, more promotion is needed for this under-utilized, free family service.

With telemedicine services becoming the new normal, there is a concern that parents are opting-out of in-person doctor's visits where young children normally receive immunizations and developmental screening. For children younger than 2, immunizations are critical, as well as the 18- or 24-month screens reaffirmed nationally by AAP and CDC guidance. Title V will be addressing this concern for FFY 2022 in a new state priority to promote child wellness visits.

Plans for FY 2020 began well with the new ECCS Impact Coordinator fully prepared to expand grant activities, having been in the position for a year. Connecting Maui pediatricians to the CDC Act Early Ambassador started in FY 2019, with more activities to follow through 2020. However, the pandemic concerns and switching the in-person training to online resulted in reduced provider/client attendance. Providers showed interest in the new developmental screening tool, the Survey of Wellbeing of Young Children (SWYC), but were concerned that referrals for family well-being needs were not clearly identified. Most Maui early childhood providers continue to use the ASQ-3. Training is available for providers to learn more about this tool.

In FY 2020, Title V began discussions with the AAP-Hawaii Chapter and Hawaii's Medicaid agency to promote use of the SWYC since it was added to the national AAP list of validated screening tools. Because the SWYC is a free tool and also covers behavioral and family well-being (including social determinants of health), referrals may be broader than IDEA Part C (EI services) and Department of Education developmental services. Hawaii will continue to work with partners on adoption of this new tool that can also help screen and identify social-economic needs of children and their families.

To support physician concerns about an accessible referral site for information for families, planning is underway to create a centralized resource directory of state services. Title V is part of a workgroup led by Hawaii's First Lady to create the directory that is building on an existing Executive Office on Aging project, 'No Wrong Door' that is creating a coordinated intake and referral system to access a large array of state services.

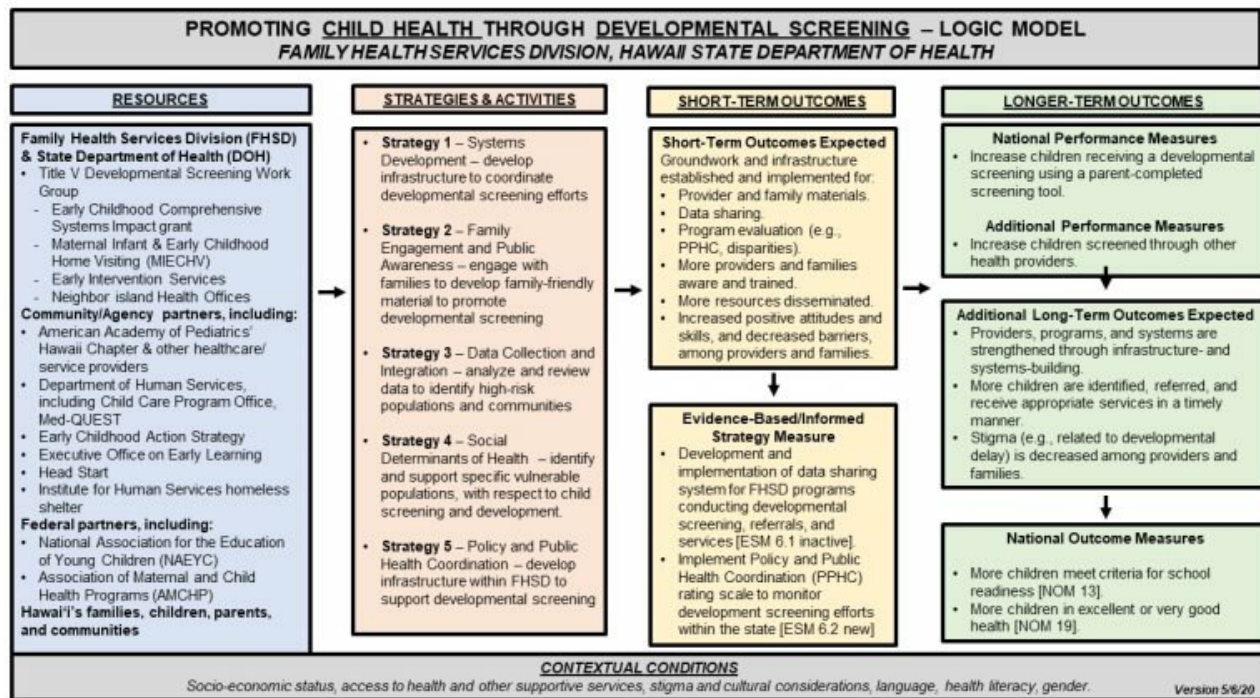
Hawaii applied for and received a technical assistance grant from the Centers for Disease Control and Prevention (CDC) on COVID-19 Act Early in September 2020 work. As part of the one-year grant, a needs assessment was conducted on system partners who participate in the developmental and autism screening process, including those who promote child development, conduct developmental screenings with families, refer families for concerns, and provide services and supports for families with children identified with a developmental delay. Strategies to address barriers to care and strategies to improve resiliency among children and families are being developed/implemented.

Hawaii applied for and received the new iteration of the ECCS Health Integration Prenatal-to-Three Program (HIPP), which will not focus on developmental screening but will instead address the infrastructure needed for a coordinated maternal and infant childhood system of care that may help strengthen screening infrastructure and supports.

Review of Action Plan

A logic model for Title V NPM 6 was modified based on the ECCS Impact Grant to include Title V measures (NPM, ESM, NOM). Strategies were developed with consideration of community, statewide, and national efforts. Strategies included input from partners and additional feedback from families and providers solicited at conferences and

community events. The major strategies for the work plan revolve around the areas of Systems Development, Family Engagement and Public Awareness, Data Collection and Integration, Social Determinants of Health, and Policy and Public Health Coordination.



By working on these five strategies, Hawaii plans to meet its NPM of increasing the number of children receiving a developmental screening using a parent-completed screening tool by addressing systemic challenges. This includes working with families to promote understanding of the importance of completing the screening tool, using data to address areas of concern, and working on policy and public health coordination. By addressing all areas of the logic model and rating scale, there will be consistent information and guidance to providers. Hawaii will also address social determinants of health to focus efforts on communities of greatest need. Hawaii continues to use this logic model to guide its work on strategies and activities.

Challenges Encountered

A recent needs assessment conducted by the Hawaii Act Early COVID-19 team found many challenges to expanding developmental screening – some of which are COVID-19 related and ongoing infrastructure development. Challenges remain in the areas of policy, data, and messaging.

Timeliness of Referrals: Hawaii's Title V Developmental Screening partners have always been concerned about the timeliness of referrals and getting supports to children who have been screened. While screening itself is important, it is critical that children identified with a concern are evaluated in a timely manner in order to ensure their access to needed services. To ensure timely intervention, providers conducting screenings are required to refer children in the "referral range" to EIS within seven days after identified, per the federal IDEA statute. However, programs and providers maintain their own guidelines and protocols for referrals. The seven-day referral standard needs to be more widely promoted and adopted to assure timely referrals.

Coordination with Medical Home: Coordination with referring agencies may become strained, since EIS is not allowed to share follow-up protected information/results unless a parent signs a consent form allowing EIS to share

information with the referral source. Since the consent is not always easily attained in a timely manner, referring providers can get frustrated and stop referring clients to EIS for services.

Educational Services: For children over 3 years of age, parents of children with developmental issues are often challenged to access school services because the evaluation must clearly show a direct impact on a child's learning or education. However, screening results may not always be considered as part of the evaluation by the school system. It became the responsibility of parents to demonstrate how a developmental concern adversely impact a child's education and learning. This can be a frustrating process for families.

Data: There is still no unified/population-based data collection system on developmental screenings to monitor children who are screened, referred, and receiving service in the state. Other states have similar challenges because no one data system collects developmental screening and referral efforts. Because of this, efforts to target communities and populations of greatest need are hampered. Medicaid may be the best option if MQD can begin to report on the CMS core children's healthcare quality measures on Developmental Screening. Approximately 40% of Hawaii's children are insured through Medicaid and enrollments significantly increased in 2020. Generating screening data for this population would be invaluable to develop effective strategies.

Currently, EPSDT data use is limited because the data tracks healthcare visits and not actual screenings. Hawaii hopes to address this issue via Medicaid and other health insurers as part of the new ECCS grant. More accurate data would help allow the state to pinpoint promotion and education efforts.

Public Awareness and Messaging: Prior to COVID, parents/providers identified many barriers for parents to complete a development screening of their children, including lack of time, lack of understanding of the importance of parental engagement, and fears of stigmatizing children. COVID created additional challenges to accessing preventive care/screenings, given the drastic shift of family priorities to more immediate survival concerns. Service providers shared insight on other barriers faced by families during COVID:

- Parents having competing priorities (food, rent, work)
- Parents are stretched to the limit with school/working from home
- Parents do not have tools to assist with monitoring, lack of supports if there are concerns
- Parents lack of confidence in their parenting skills and in serving as observers
- Lack of understanding about child development and developmental milestones and lack of awareness of children's different rates of learning
- Closures of programs (preschools, schools, peer education, etc.)
- Lack of bandwidth in rural and insular areas of the state
- Disconnect between providers and families on the use of telehealth

Efforts through the CDC Act Early grant and the new ECCS grant will assist with addressing these problems raised by the needs assessment; however, work may be delayed based on the course of the COVID virus.

Overall Impact

Over the past five years, Hawaii was successful in convening statewide stakeholders to develop and complete standard guidelines for development screening, which can be used for all programs and services working with young children. The guidelines are available through several public and early childhood websites. Training on the guidelines have been widely conducted, and trainers on the guidelines are embedded in early childhood agencies in all the counties as resources for their community partners.

The Early Childhood State Plan and other early childhood coalitions identified developmental screening as a key

priority over the past five years. By working together to address this issue, providers and partners are now more aware of the importance of developmental screening using a validated screening tool, ensuring needed referrals are timely and communication with the medical home. The work to promote a more seamless system of screening and referral will be continued and expanded.

Although population-based data remains an issue, Title V was able to coordinate routine data sharing around development screening for four of its early childhood service programs to assure development screening was occurring and needed referrals were made for follow-up when needed. Although, the creation of an integrated data system proved too costly and challenging to develop, the four programs meet regularly to share developmental screening data for quality assurance purposes and now readily collaborate to address any issue/barriers that emerge. Thus, ESM 6.1 was retired since it was completed.

Title V has also made great progress working directly with pediatric providers in the AAP-Hawaii Chapter, by collaborating with Hawaii's CDC Act Early Ambassador, Dr. Jeff Okamoto. Title V has also strengthened its collaboration with the Med-QUEST Division over the past year and looks forward to addressing policy and data issues and promoting the new SWYC screening tool to address the social determinants of health.

While service system providers are more aware of the development screening, continued effort is needed to reduce the stigma that may prevent families from seeking follow-up services for their child. Normalizing the conversation and making screenings part of a well-child visit or a routine early childhood practice helps to ensure screenings and follow-up occur. Partnerships with the AAP-Hawaii Chapter and Medicaid will help to share consistent information about screenings and referrals availability of online screenings through the Hi'ilei program.

Hawaii will continue to explore and advocate for improved national and state data on developmental screening. The NSCH reports less than one in three children in Hawaii received a developmental screen, which is comparable to the national estimate. Committed efforts by programs like MIECHV and other early childhood programs to conduct developmental screenings contribute to statewide efforts. However, the vast majority of children are not receiving developmental screenings. Thus, improved outreach is needed to promote its importance. Working with early childhood providers, efforts will continue to promote developmental screening and sharing of information with the child's medical home.

SPM 1 - Rate of confirmed child abuse and neglect cases per 1,000 children aged 0 to 5 years.

Introduction: Child Abuse and Neglect (CAN) in Hawaii

The 2015 needs assessment confirmed that Child Abuse and Neglect (CAN) prevention should continue as a priority under the Child Domain. Child maltreatment stands as a foremost concern for the state. Community needs span the spectrum from primary prevention services to support families as well as improvements to the Child Welfare Service system to prevent children from entering foster care.

Data: The latest data for confirmed child abuse cases are from 2019 as reported by the state Child Welfare Services program. The rate increased slightly between 2019-2020, from 5.5 to 5.7 per 1,000 children aged 0-5 years, thus the state objective was not met. There was a slight increase in the number of cases for ages 0-5 years (from 584 to 591). Among all age groups, infants experience more abuse at nearly 16%. Overall, children five and under accounted for 44% of all confirmed cases.

Among confirmed cases for all age groups, one death occurred due to abuse in 2019 and three children experienced permanent disabilities. Another 30 children experienced serious injuries. While most cases were reported as requiring no treatment or injuries, research studies have found residual emotional trauma due to abuse and neglect is a possibility.

In 2019, the highest reported factors contributing to the abuse or neglect of children of all ages were inappropriate child-rearing methods (64%), inability to cope with parenting responsibility (58.7%), drug abuse (41.5%), and parental mental health problems and spousal fighting/physical abuse (13.8 and 12.9%) respectively. Hawaiian/Part Hawaiian children were over-represented among confirmed CAN cases for all age groups (40%). Caucasian children are second, at 20%. The reasons for these disparities are unclear, but for the Hawaiian/Part Hawaiian children, are likely related to colonization and the overthrow of the Hawaiian government by the U.S., historical trauma and resulting socio-economic inequities suffered since western contact.

Continuing priority: The 2020 needs assessment confirmed that CAN prevention remained a state priority. Input from stakeholders was considered to revise the CAN strategies for 2020-2025. The objective is set at a 5% improvement over the next 5 years.

Title V Lead/Funding: The Title V Child Abuse and Neglect Prevention Program (CANP-P) is administratively located in the Maternal and Child Health Branch (MCHB) Family Support and Violence Prevention Section (FSVPS). The Section is made up of the sexual violence, domestic violence prevention, parenting support programs, as well as the Maternal Infant and Early Childhood Home Visiting (MIECHV) program. The CANP-P is funded by the Administration for Children and Families (ACF), Community-Based Child Abuse Prevention (CBCAP) formula grant. While Title V does not directly fund CAN prevention activities, it does fund key staff positions related to the program, including the FSVPS Section supervisor and other MCH Branch support staff such as the Branch research statistician.

Strategies: Child abuse and neglect are complex problems rooted in health inequities, unhealthy relationships and environments. Preventing CAN requires addressing factors at the individual, relational, community, and societal levels. Hawaii's 2016-2020 CAN prevention strategies reflect a broader public health systems approach:

- Collaborate on and integrate child wellness and family strengthening activities across programs.
- Raise public awareness about the importance of safe and nurturing relationships to prevent child abuse and neglect.
- Provide workforce training and technical assistance for service providers to promote safe, healthy, and respectful relationships to prevent child abuse and neglect.
- Collaborate with the Hawaii Department of Human Services Primary Prevention Initiatives.

Evidence: While CAN Prevention is not a Title V NPM, research presented by the MCH Evidence Center from the Child Safety Network supports Hawaii's cross-cutting strategies that leverage partnerships to support evidence-based/informed programs and practices.

The CANP-P focus is primary prevention. Grant funds are used to support community-based efforts to develop, operate, expand, enhance, and coordinate initiatives, programs, and activities to prevent child abuse and neglect and to support the coordination of resources and activities to better strengthen and support families to reduce the likelihood of child abuse and neglect. Also important is efforts to foster understanding, appreciation, and knowledge of diverse populations in order to effectively prevent and treat child abuse and neglect.

COVID Impacts: Hawaii's COVID-19 stay-at-home orders instituted in March 2020 alarmed many social service agencies concerned about the increased potential for family violence, including CAN. Limited real-time data is

available at this time to confirm this concern. The widespread closure of businesses, public amenities, and shelter-at-home orders along with COVID fears; created unprecedented social isolation and stress for families. Furloughs and layoffs imposed a serious economic strain on families. The closure of schools and daycare services added to the burden on families with young children, particularly for mothers.

Services like the Domestic Violence Action Center reported dramatic increases in calls for information and assistance during the pandemic, while Child Welfare Services staff reported a marked decrease in suspected CAN reports.

Strategy 1: Collaborate on and integrate child wellness and family strengthening activities among programs.

The complexity of risk factors relevant to prevent and reduce CAN requires collaboration with diverse private and public organizations, including those that directly engage in CAN work, as well as agencies addressing broader community concerns (e.g., housing, employment, safe neighborhoods, substance use, etc.). Key collaborations are described below.

CANP-P collaboration continued with the Department of Education five-year Trauma Recovery Project, developed to ensure that low-income students who experienced trauma received trauma-specific mental health services from providers that best meet their needs, and to move the CAN system to use Trauma-Informed Care/Responsive standard of care. The Project is an important collaboration for DOH, the DHS and community organizations. The CANP-P Coordinator serves as a member of a Core Implementation team for the project.

Family Strengthening and Violence Prevention Section (FSVPS) programs supported prevention activities and trainings, sharing resources and data, and coordinating training and technical assistance (TA) opportunities. These efforts serve to create a foundation for healthy relationships between parents and with children, including the Sexual Violence and Domestic Violence Prevention programs.

Federal MIECHV funds supported the Hawaii Home Visiting Program (HHVP), providing voluntary, evidence-based home visiting services to at-risk pregnant women and parents with young children. In fiscal year 2019-20, the HHVP provided direct preventive services to 565 adults and 561 children. The HHVP also partners with Title V early childhood and perinatal programs to promote family/child wellness.

The MCHB Parenting Support Program (PSP) administers family strengthening contracts for parenting and child development services statewide. Services include The Parent Line (<http://www.theparentline.org/>), a telephone warm-line for parents, information dissemination on child development and community resources; short-term in-home parenting support, and parent-child interactive education groups for homeless families. CANP resources and services are available through these contracts. The PSP also supports the Safe Sleep Hawaii coalition.

The CANP-P Coordinator participates in the Early Childhood Action Strategy (ECAS) Initiative, a statewide public-private collaborative focusing on children from prenatal to age eight to strengthen and integrate the early childhood system services. The team is involved in the implementation of the *Nurture Daily* project, which supports the dissemination of informational tools and products to enhance the quality of interactions within families.

The Hawaii Children's Trust Fund (HCTF), a public-private partnership between the Department of Health and the Hawaii Community Foundation (HCF). Its structure includes a statewide Coalition, an Advisory Board (AB), and an Advisory Committee (AC). The mission of HCTF is to ensure that Hawaii's children develop into healthy, productive, and caring individuals by promoting the advancement of community family strengthening programs to prevent child

abuse and neglect.

Representatives from the Department of Education, the Judiciary, the Department of Human Service's Office of Youth Services, and the DOH serve on the AC, with the DOH serving as the lead public agency. The CANP-P Coordinator supports the AC Chair for various administrative functions. The HCTF is a grantmaking vehicle under the HCF.

Efforts to develop Hawaii's first CAN Prevention Plan continued under the direction of a Steering Committee which is comprised of a subgroup of members of the HCTF Advisory Committee and several community-based agencies. The Centers for Disease Control and Prevention's "*Essentials for Childhood*" was adopted as the framework for the plan. Work on the plan was delayed due to COVID-19 and meetings shifted from in-person to virtual. The impact of COVID-19 raised new needs and challenges as well as opportunities for expanded collaborative efforts.

Strategy 2: Raise public awareness about the importance of safe and nurturing relationships to prevent child abuse and neglect.

As a result of the COVID pandemic, efforts to support families and communities shifted from in-person to largely commercial media and virtual formats. Health and social service agencies responded with messaging campaigns on social media, TV, and radio, creating new remote resources for family support, and providing information on family violence, mental health resources, and essential services/resources to address immediate family needs.

One example was Maui County's virtual CAN prevention event hosted by the Ho'ouikaika Partnership, CoMMIT for Keiki, and Islands of Hope-Maui (IOH). The Maui mayor's office encouraged residents and county staff to wear blue that day to promote CAN prevention and to participate in the event through virtual fun family activities. John Cruz, a Hawaii Grammy-winning performer, recorded a video of his song '*Island Style*' to use as the theme for the day. Families were encouraged to post videos or pictures of their families wearing blue and dancing to the song. The Maui Family Support Services created a YouTube video to help support families through the pandemic.

Partnering with Aloha United Way, the Ho'ouikaika Partnership created multi-lingual flyers and social media graphics about the free 2-1-1 resource hotline to help families access a comprehensive listing of support services. Flyers were printed and distributed statewide through the DOE grab-n-go meal program that reached 68 schools. The goal of the project was to ensure that non-English speaking families across Hawai'i were aware of the hotline that provided information in over 150 languages.

MCHB developed several public service announcements (PSA) focusing on safe and nurturing families, healthy relationships, and promoting the state Parent Line resources. The PSAs were broadcast statewide on major local media outlets. MCHB also secured three time slots on a local television station with tips on staying connected, keeping children busy and happy at home, and managing stress.

CBCAP funds originally designed for in-person events were shifted to support programs directly addressing risk factors for CAN such as poverty, stress, mental health issues, and social isolation due to COVID. Examples of a few of these initiatives were:

- On Oahu, a food distribution program provided meals to 250 new and pregnant moms each week, with culturally appropriate education materials for pregnant women, mothers, and their families that were created and distributed.
- Hawaii County's efforts included expanding professional mental health services to para-professional family strengthening and CAN prevention services.
- A community provider on Molokai adapted an in-person sexual violence prevention curriculum for elementary

and middle schools to an online format.

- Kauai partners implemented a variety of small projects related to CAN prevention including: a Marshallese translation of family strengthening information and other resources; a list of on-island community resources, information on child abuse reporting, and COVID-19 testing sites (information was made available in English and other languages). They also started a new parenting group.

During the pandemic, ECAS conducted a soft launch of three PSAs to promote healthy family engagement with the theme: *Nurture Daily*. The PSAs broadcast on TV, radio, and social media with themes: *Take Time to Share a Story*, *Take Time to Share a Compliment*, *Take Time to Teach Life Skills*, and *Share Time Helping Each Other*. This effort occurred in conjunction with the dissemination of Safe and Nurturing Families Educational Resource Guides, informational tools, and products utilizing Nurture Daily messages and promoting Trauma-Informed-Care (TIC) trainings to support more quality family interactions.

Strategy 3: Provide workforce training and technical assistance for service providers to promote safe, healthy, and respectful relationships to prevent child abuse and neglect.

Despite COVID, the CANP program continued to conduct virtual statewide trainings on:

- TIC strategies for early childcare providers,
- the impacts of Adverse Childhood Experiences, the effect of toxic stress on infant brain development,
- the Strengthening Families Protective Factors Framework, an Approach to Resilience Building,
- Standards of Quality for Family Strengthening and Support, and
- Be Strong Families curriculum based on the Parent Café model.

The FSVPS program staff and the Early Childhood Coordinator under the Children with Special Health Needs Branch put together a cohort of community-based service providers who received training to expand their skill sets on ACEs and resilience in their daily work with families. In-depth training was provided by Dr. Sara Watamura, from the University of Denver. Cohort members were tasked to use their skills within their own organizations and with their larger community. The training was paused due to COVID demands on service agencies and may be resumed later.

The HHVP offered ongoing training and TA to their contractors in promoting child development, encouraging positive parenting, and working with caregiver participants to set attainable goals for the future to prevent CAN.

Strategy 4: Collaborate with the Hawaii Department of Human Family First Prevention Service Act (FFPS)

CANP-Program collaboration with the Hawaii Department of Human Services focused on supporting planning efforts for the Family First Prevention Services Act (FFPSA) and implementing the new 2020-2024 Child and Family Services Plan (CFSP). Under the FFPSA it was critical to determine which programs and services used in the state were rated as well-supported, supported, promising, or does not meet evidence-based criteria according to the Title IV-E Prevention Services Clearinghouse. The CANP-Program participated in an environmental scan of services. As a result of the scan, a matrix of services was created showing a range of parameters such as geography, interventions used, funding source, and the cultural responsiveness of the organization.

The CANP-P Coordinator continued to serve on the Hawaii State Team to support the implementation of select 2020-2024 Child and Family Service Plan (CFSP) strategies. The Team focused on three areas: (1) supporting the Hawaii Zero To Three Court initiative and the families and children served by this program (2) expanding the Department of Human Services (DHS), Child Welfare Ohana Time system of care and services, and (3) reviewing connections to resources for families including identifying any gaps in services.

Highlights for FY 2021 through June 2021

COVID-driven workplace closures continued to temporarily halt/disrupt CANP activities. The CANP-P Coordinator worked with the contractors to modify contracts to move from in-person to virtual services and events to meet COVID safety guidelines. Contractors were largely successful in shifting to virtual trainings and events to meet the needs of their communities, despite COVID restrictions.

Both the Parenting Support Program and the Hawaii Home Visiting Program also worked with their contractors to move from in-person services and activities to virtual home visits with parents and community activities.

Ongoing impacts due to the pandemic generated an urgent need to develop new approaches to expand services and resources for families, service providers, state and county offices, and the general public. Most outreach/services pivoted to virtual formats and use of social media platforms. However, this shift highlighted existing inequities in community broadband access and digital devices. Many service providers and clients did not have ready access to internet service, computers, hot-spots, and/or flash-drives. With greater federal flexibility, the CANP-Program expanded funding criteria allowing for the procurement of IT equipment to ensure uninterrupted virtual connection between clients and providers as well as offering school supplies for children, sanitary and cleaning supplies for families, and other emergency supports.

COVID also amplified interest in and application of Trauma-Informed Care (TIC). The CANP-Program convened private and public program leaders to share TIC practices and policies promoted in their organizations, emerging needs, and next steps for collaboration. The group identified several needs including: standardized TIC language and practices; the ongoing workforce development/training on TIC models and practices; and addressing trauma-informed systems of care.

A draft of the Hawaii Statewide CAN Prevention plan was released to the HCTF Steering Committee for review and comment. The Steering Committee agreed the document would serve as a conceptual framework based on five key pillars – Commitment, Supports and Services, Communities, Policy and Coordination - to build a successful public health approach to CAN prevention.

Hawaii CBCAP received a five-year, \$1M award under the American Rescue Plan Act (ARPA). Use of both ARPA and CBCAP formula funds follow a prevention approach to expand and enhance community-based, prevention-focused programs and activities and specific family resources that focus on healthy and positive development of parents and children. Hawaii's funds will be used to plan and develop an integrated prevention continuum of services, policies and practices across state and county government offices and programs to support and facilitate families to provide safe, stable, nurturing relationships and environments for their children.

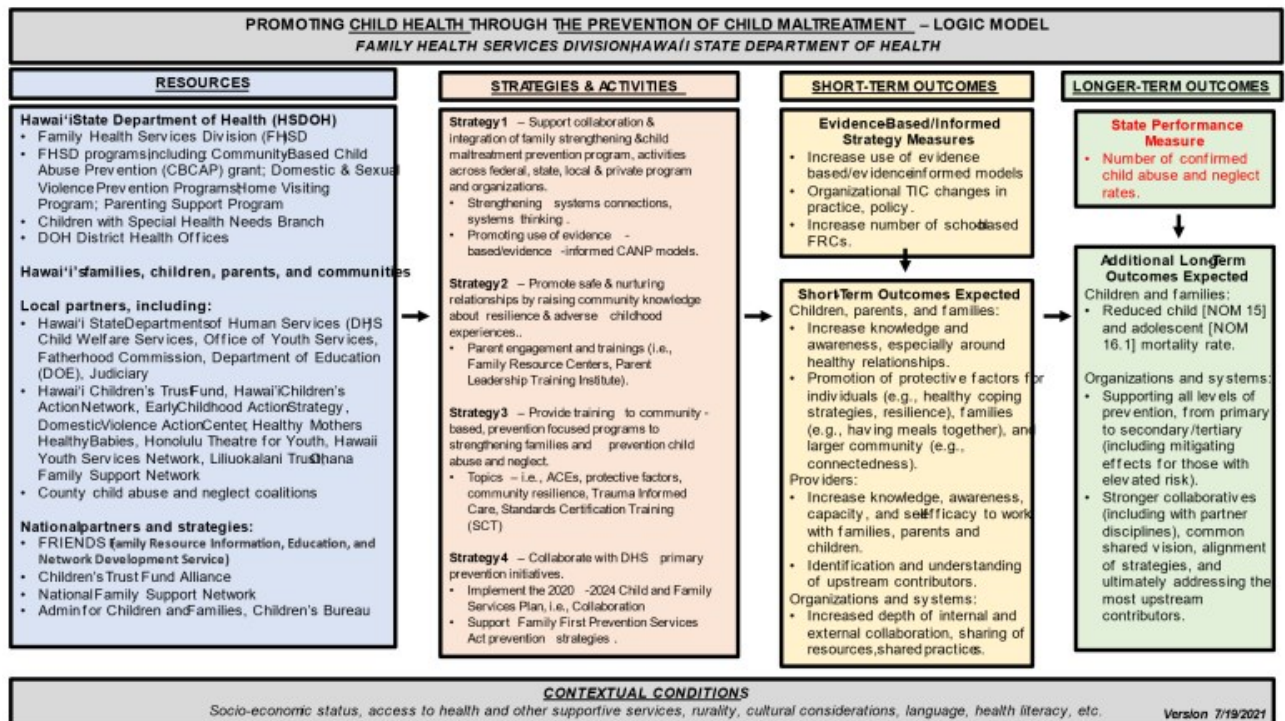
The State Departments of Health, Education, Human Services, and Judiciary currently collaborate on several important CAN prevention initiatives that are a combination of primary, secondary, and tertiary prevention efforts. The collective impact of the existing collaborations will be enhanced by developing a common understanding of the CAN prevention service system continuum. The vision is to expand the current collaboration to include the Hawaii State Departments of the Attorney General, Public Safety and Executive Office of Early Learning under the Governor's Office, as well as integrating county-level CANP resources.

Funds may also be used to support the expansion of school-based Family Resource Centers in the state.

The CANP Program serves on the Ohana Family Support Network core team that is planning near- and long-term initiatives and provided funding of Standards Certification training for education and community partners.

Review of Action Plan

The revised CANP logic model describes the 2020 strategic approach. Preventing CAN cannot be addressed as a stand-alone public health concern. The logic model confirms the importance of acknowledging and addressing contextual conditions that impact and influence CAN negatively or positively, in tandem with programs that specifically target violence prevention. The logic model also captures the broad array of public partners/resources to address CAN in Hawaii.



Challenges and Barriers

COVID challenges: A 2021 survey commissioned by the DOH found that COVID-19 is affecting the mental health of a majority of Hawaii residents. Of 445 Hawaii adult residents surveyed, 82% said that they have experienced a mental health condition at some point over the last six months, and about 50% of those say their symptoms began during the pandemic. Consistent with these findings, Hawaii CARES (formerly the Crisis Line of Hawaii) received its highest annual volume of calls in 2020 compared to the prior seven years of operation, receiving more than 16,000 calls in September 2020. The increased stressors on households and social isolation of children and families continues to raise concerns regarding the potential of unreported family violence.

Title V FSPVS contracted service programs have rapidly shifted from largely in-person services and community events to virtual outreach and visits. However, some service providers did not have sufficient IT equipment. Clients also often lacked access to broadband, digital devices, and skills to use the software programs. Rural communities were impacted by the lack of reliable broadband service. Innovative outreach to the professionals and the public required shifting to virtual platforms to learn new methods of engagement. Using federal relief funds state programs responded by issuing laptops, hotspots, as well as training on using the equipment. CBCAP funds were used to support at-risk Micronesian communities to procure supplies and subscriptions to assist children to participate in distance learning as well as attend telehealth appointments.

CANP training and activity contracts were written requiring expertise in providing and facilitating virtual platforms as

well as creating new mechanisms or vehicles to engage community members and new partnerships.

Moving to virtual events and trainings produced positive outcomes in terms of cost-savings and capacity. With dollars traditionally spent on logistics, food, travel and other in-person costs eliminated funds were used to expand services and resources. The use of virtual platforms supported a significant increase in the number of people who could participate in trainings, webinars, and other events as policies restricting travel were no longer relevant. As the competencies of those bringing the training and those attended grew, the full array of virtual platforms, i.e., breakout rooms and software, i.e., Padlet almost duplicated the in-person experience.

Overall Impact

Key overall CANP impacts over the past five years include:

- Building and expanding the inclusion of prevention strategies in DHS 2020-2024 Child and Family Services Plan and FFPSA initiatives.
- Coalition building and partnerships with state and community-based programs and organizations.
- Creation of a CANP Plan in partnership with private and public partners.
- Workforce development trainings and conferences on ACEs, resilience, trauma-informed care, toxic stress, and Standards of Certification.
- New collaboration with the Hawaii Department of Education on a 5-year Trauma grant and piloting of school-based Family Resource Centers.
- Reconvening of the Hawaii Children's Trust Fund Coalition.
- Adoption of the trauma-informed model by private and public organizations.
- Ongoing funding of community-based programs addressing CANP awareness and strategy building and strengthening families.
- Launch of *Nurture Daily*, an internet resource for families and providers.

SPM 5 - The percentage of Medicaid children receiving six or more well-child visits in the first 15 months of life

Introduction: Well Child Visits and Immunizations

For the Child Health domain, Hawaii added this new state priority to promote child wellness visits and routine immunizations especially for young children. The priority is a result of ongoing needs assessment and concerns raised during the COVID-19 pandemic that many well-child visits and immunizations were postponed or delayed due to lockdowns and safety concerns.

Importance of Well Child Visits: These visits are an important venue for counseling, as well as vaccine administration and documentation. At well-child visits, providers can also screen for developmental delays and parents can raise concerns about a child's physical problems, behavior, and mental health and receive personalized guidance on healthy nutrition, exercise, and safety. In-person visits help with capturing biometric data such as the height/weight/head circumference, hearing and vision screening, blood tests (lead and cholesterol), immunizations, blood pressure and other vitals, oral exam, autism screening, and tuberculosis screening. Healthcare providers can provide anticipatory guidance and help support parents or caregivers with any questions or concerns about their child's development.

National concerns: Nationally, the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services released data early in the pandemic documenting dramatic decreased rates of child immunizations and well-child visits. Data from the U.S. Census Pulse survey also confirmed overall trends in

postponed medical care during the pandemic. The concern was amplified by the American Academy of Pediatrics, which launched a national 'Call Your Doctor' campaign in May 2020. The federal MCH Bureau also launched a similar social media campaign, WellChild Wednesdays, in 2020; and in 2021, funded a national challenge for innovative projects to increase child wellness visits.

Hawaii: Preliminary Medicaid data showed a decrease in child wellness visits in 2020 (although the data likely also reflected a 9-12-month reporting lag by the health plans). DOH Hawaii's Immunization Branch also reported a sharp decline in vaccination requests by providers once the pandemic began in 2020.

Title V programs: In 2020, most Title V direct service programs saw overall reductions in service provision due to the pandemic as in-person visits were halted and all services pivoted to virtual or phone visits. The pandemic also shifted family priorities to addressing essential daily needs. However, the Title V programs did notice similar trends in reduced child wellness visits and vaccinations for those served. Early Intervention Section (EIS), Hawaii's IDEA Part C Agency, also saw a decline in referrals from pediatricians, traditionally the largest referral source. The Hawaii Home Visiting Program convened a meeting to share data, information, and develop a response.

Partners: The Title V leads for this project include the Home Visiting Program, the Early Childhood Systems Coordinator, and FHSD Public Information Officer. Other programs include EI, Lead Screening, WIC, and CSHN. The key external partners are the AAP-Hawaii Chapter, State Medicaid program, and Hawaii Children's Action Network (HCAN).

Title V Lead/Funding: State general funds were used to cover the major costs for the media and community outreach campaign.

Evidence: Although there is no specific MCH Evidence on well-child visits, the evidence for Adolescent Well-Visit strategies and Medical Home were reviewed. Patient reminders are identified as Emerging Evidence as a way to increase well-child visits. Another tangential topic of the medical home shows collaborating with home visiting as an emerging evidence. Since Hawaii will be using the data from home visiting and the home visiting families to develop and test the messages, this may be a useful strategy. An MCH Evidence Center brief on public health messaging was also reviewed that showed some evidence for this strategy, especially when reinforcing a mass media campaign with social media and community coordination.

Objective: By July 2025, increase the percentage of Medicaid children receiving six or more well-child visits in the first 15 months of life.

Messaging/Outreach Strategy: This new project will work with pediatric providers, community advocates, and the Title V/FHSD programs to promote well-child visits and immunizations. Hawaii plans to conduct a public awareness campaign starting in September 2021 through December 2021.

Strategies include:

- Collaborate with pediatric providers and community advocates to promote messaging on importance of well-child visits.
- Conduct public awareness campaign and measure effectiveness of messaging (increase number of visits to the doctor, increase number of vaccinations for the home visiting population).
- Build capacity for developing pediatric champions to promote messaging campaign.

Report on Current Activities through June 2021

Hawaii convened a Child Wellness Visit workgroup (CWV) to develop the public awareness campaign starting in September 2021 through December 2021. As part of promoting the importance of the well-child visit and immunizations, a critical partnership is with the pediatric providers as they will be impacted by efforts to promote in-person visits and immunizations. By working with AAP-Hawaii Chapter leadership, this will be an opportunity to make sure that the pediatricians are aware that this campaign will be launched and what is expected and anticipated. AAP leadership gladly joined the workgroup, which has been meeting regularly through 2021. The Medicaid Medical Officer, who is also a pediatrician, has joined the workgroup along with the Clinical/Community Services Nurse. Both are helping to secure data and coordinate with the state's health plans.

Once funding was secured, contracts were executed with AAP-Hawaii, media vendors, and HCAN to coordinate the community campaign. The workgroup is meeting to:

- Develop messaging
- Collect parent input to identify the barriers to care
- Test messaging with families in home visiting, Parent Leadership Training Institute (PLTI), and other Title V service programs
- Identify referral for families to secure insurance or find a provider if needed

NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Introduction: Child Oral Health

For the Child Health domain, Hawaii selected NPM 13.2 (children's oral health) based on the 2015 five-year needs assessment. By July 2020, the state sought to increase the percent of children, ages 1 through 17, who had a preventive dental visit in the past year to 86.0%.

Data: Aggregated data from 2018-2019 show that the estimate for Hawaii (85.5%) nearly met the 2020 state objective, and was significantly higher than the national estimate of 79.6% for preventive dental visit among children. Children 1 through 5 years of age had a lower estimate (72.4%) compared to children 6 through 11 years of age (90.4%), and 12 through 17 years of age (92.7%). There were no other significant differences in reported subgroups by household income, poverty level, language spoken at home, nativity, race/ethnicity, sex, and household structure based on the 2018-2019 data provided.

The related Healthy People 2020 for this measure is: increase the proportion of children, adolescents, and adults who used the oral healthcare system in the past year to 49%. Hawaii far exceeds this target for children.

Objectives: This performance measure will be dropped in FY 2020, so no objectives have been set beyond 2020.

Although data from national surveys indicate Hawaii's rates of oral health status and service utilization are similar or better than the rest of the U.S., clinical data reveal a very different story. A 2015 oral health Basic Screening Survey (BSS) revealed Hawaii's third graders have the highest rate of caries in the U.S. and some of the highest rates of urgent care needs. Within this group, key disparities exist. Children who are low-income, have Medicaid coverage, and/or are Native Hawaiian or Pacific Islander suffered disproportionately throughout the state. A BSS of children enrolled in the Hawaii Head Start program reveals similar findings for young children from low income families.

A major contributor to the problem of dental disease is the lack of community water fluoridation. In the U.S., Hawaii has one of the lowest proportions of residents with access to fluoridated drinking water at 8.75% according to the

Centers for Disease Control and Prevention (CDC). In Hawaii, only federal military installations have fluoridated water sources. Fluoridation efforts continue to generate broad community opposition, including all four county water agencies that contend fluoridation will create undue operational costs and management burden.

Title V Lead/Funding: While not funded, the Hawaii State Department of Health (DOH) does have statutory responsibility for assessing dental needs and resources, planning and providing services, conducting education and training, and applying for federal funding for oral health infrastructure/services.

Family Health Services Division (FHSD), the Title V agency, is the DOH lead for oral health population-based activities. Currently, there is no dedicated staffing or funding to operate the state oral health program (SOHP). In 2018, FHSD's five-year CDC oral health infrastructure-building grant ended. Dental staffing was lost and activities curtailed. Hawaii submitted a new application for CDC funding, but the grant was not awarded due to insufficient funds.

Title V partners closely with the DOH Developmental Disabilities Division (DDD) dental staff, which operates five dental clinics on Oahu, serving primarily adults with disabilities and other special needs. DDD's dental director, Dr. Andrew Tseu, provides critical leadership and technical assistance for FHSD's program efforts. In 2020, he was appointed to the State Dental Licensing Board. Because he is also an attorney, Dr. Tseu has been instrumental in the department's dental policy work.

With the loss of program staff and funding, strategies were revised to reflect Title V's reduced resources and activities.

Strategy 1: Explore and pursue options to staff State Oral Health Program

The importance of dental program leadership and staffing is critical to sustain any program activity. With no local health departments or dental school, the State Oral Health Program (SOHP) is key in providing statewide leadership for public health surveillance, evaluation, and planning functions.

Prior to COVID restrictions, an FHSD budget request to support the SOHP staffing and operations was not included in the governor's budget proposal.

In February 2020, Title V partnered with the State Oral Health Coalition (SOHC) to support the national Oral Health Progress & Equity Network's Virtual Congressional Hill Day. The advocacy agenda included:

- Dental coverage for Medicaid adults and Medicare enrollees, and
- Increased CDC funding for the state infrastructure grant program.

Title V staff was able to join the Zoom meetings with Hawaii's four congressional offices to provide information on the CDC grant achievements and state oral health data.

Strategy 2: Surveillance – Maintain oral health surveillance activities

Following the state oral health surveillance plan, DOH continues to collect oral health data through surveillance surveys including PRAMS, BRFSS, and YRBS. Limited oral health data is available on the DOH data warehouse website, <http://www.hawaiihealthmatters.org/>. Data activities were limited in 2020 with vacancies in FHSD's two epidemiologists positions.

The Title V Office of Primary Care and Rural Health continued to monitor workforce shortages and establish federal designations for health professional shortage areas (HPSA) for dental services. In 2020, dental HPSAs existed on all islands and the entire islands of Hawaii, Maui, Molokai, Kauai, and Lanai are dental shortage areas (see HPSA maps in Supporting Documents).

Strategy 3: Partnership/Coalition-Building-Support ongoing partnerships and coalition-building activities

The CDC oral health grant helped to rebuild Hawaii's state oral health coalition, providing funding to the Hawaii Public Health Institute (HPHI) and Hawaii Children's Action Network (HCAN) to support the Hawaii Oral Health Coalition (HOHC). The coalition continued to grow and develop its identify and infrastructure:

- Convened regular committee, leadership, and neighbor island task force meetings.
- Registered coalition members now numbering 376
- Updated the coalition website with community information and resources
- Finalized logo selection

HOHC routine activities were halted in March due to COVID-19. During this time, however, HOHC was able to pivot and worked on the following activities:

- Provide two webinar trainings with CE credits provided by the state Department of Health. Both webinars featured Dr. Paul Glassman: *Teledentistry in the Era of COVID-19 and Beyond* and *A Deep-Dive into Implementing Teledentistry into the Dental Practice Confirmation*. Both webinars were recorded and posted on YouTube.
- Shared initial safety/infection control guidelines for the pandemic emergency and, as of June, regular dental visits.
- Served as a hub for communication around PPE access for dental practices and encouraged purchasing partnerships among dental professionals
- Provided oral hygiene kits to vulnerable children through grab-and-go meal sites on Oahu.
- Continued advocacy for Medicaid coverage of adult dental benefits during the legislative session. Prior to COVID, the legislation was progressing toward passage.

A new ESM was created for FY 2020, focusing on the state coalition work. ESM 13.2.3 is the number of organizations and individuals participating in State Oral Health Coalition meetings and activities. Although the formal membership enrollment registration system was not established in FY 2019, there were 64 participants in the meetings that helped establish the HOHC organizational structure, a slight increase over the previous year's meeting participants.

ESM 13.2.3 – The number of organizations and individuals participating in State Oral Health Coalition meetings and activities.

	2018	2019	2020	2021	2022	2023	2024	2025
Annual Objective		55	60	65	70	75	80	85
Indicator	48	64	64					

Other partnership activities included the pilot teledentistry programs on Hawaii Island and Maui. The DOH dental director for the Developmental Disabilities Division is providing technical assistance for the project. The site at the West Hawaii Community Health Center is in its fifth year providing services to young children at Head Start, WIC,

and a traveling preschool. The Native Hawaiian Health Center on Maui is the teledentistry provider on Maui serving children at Head Start and WIC as well as a senior assisted living facility. The project also included an oral health professional educational component in collaboration with the Maui Community College Dental Hygiene School. Both programs were halted due to COVID restrictions that closed Head Start, preschool, and senior living programs and ended in-person WIC visits.

Title V continued to contract with 16 community-based health service programs, including the Federally Qualified Health Centers (FQHC) to provide primary care and dental treatment services for the uninsured and under-insured. Many FQHCs, like private dental practices, largely closed their offices for several months during the initial shutdown following national guidance as well as a severe shortage of PPE. Eventually, dental practices slowly resumed services during the summer with increased infection control measures. Anecdotally, dental practices have reported incurring greater cost and reduced appointment availability due to additional sanitation measures. Several FQHC dental directors have also reported seeing more severe cases of dental disease as offices reopened.

Current Year Highlights for FY 2021 through April 2021

Activities in FY 2021 are briefly described below.

- HOHC continued its advocacy work despite COVID restrictions during the 2021 Legislative session. Many of the bills were not heard due to policymakers' focus on COVID-related priorities. The coalition policy agenda included:
 - Adult preventive dental benefits for Medicaid enrollees
 - Expansion of dental assistants practice act to participate in teledentistry
 - Support for other public health related legislation for Sugar Sweetened Fee and Smokefree multi-unit dwellings

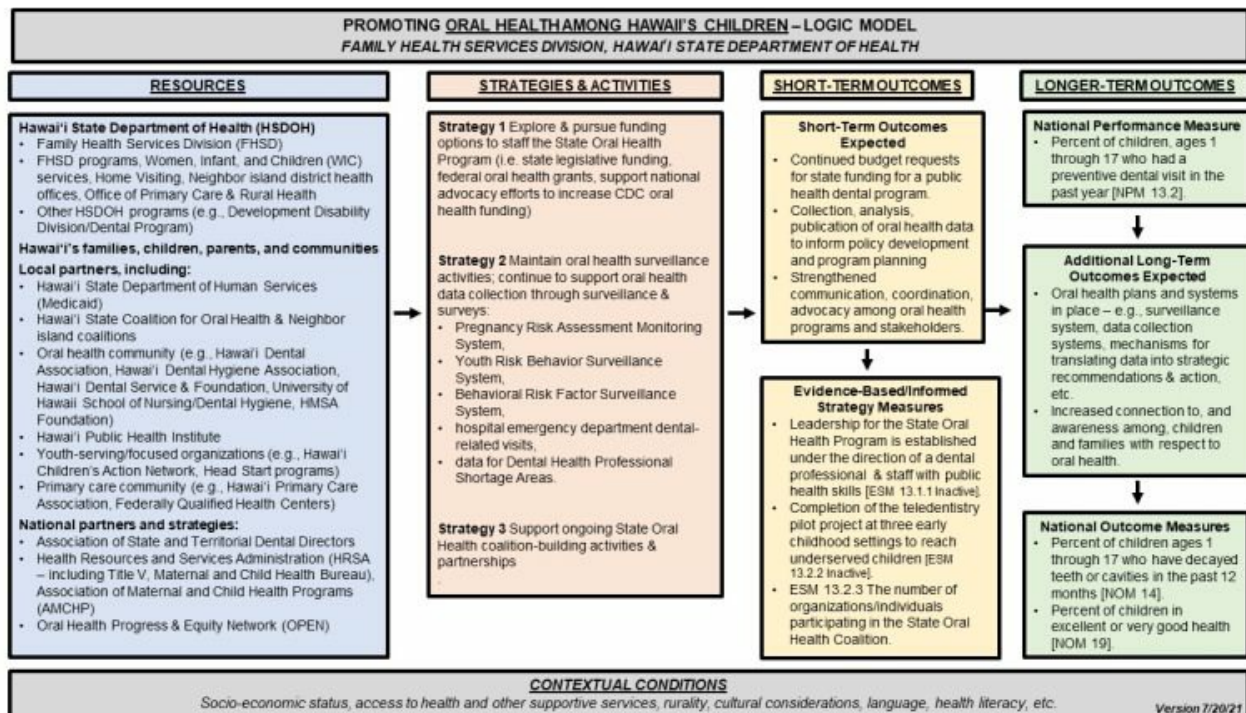
FHSD was able to shift state fund savings from direct service programs to support several oral health projects:



- Support for oral health messaging and promotion to encourage dental check-ups delayed due to COVID-19 shutdowns and safety concerns. Targeted messaging will be developed for high-risk populations.
- Provide general State Oral Health Coalition support
- Complete update of an environmental scan, including opportunities to advance medical-dental integration.
- Develop of an oral health data tracker in the state data warehouse.
- Purchase data for 2020 oral health related visits to hospital emergency departments statewide. Data analysis is pending due to limited staffing.
- Contract the University of Hawaii Office of Public Health Studies for data analysis and interpretation of state-added BRFSS oral health questions from the 2019 survey focusing on barriers to dental care.
- Develop an oral health training curriculum for community health workers.
- Contract the University of Hawaii School of Nursing and Dental Hygiene to develop a training video and toolkit to integrate oral health in a pediatric wellness visit.

Review of Action Plan

The logic model reflects the reduced work of FHSD due to the loss of dedicated funding and staffing. Efforts focus on activities by the State Oral Health Coalition. Oral health data sources critical for ongoing surveillance efforts were also detailed to reflect the infrastructure services supported by Hawaii Title V.



Overall Impact

The CDC oral health grant was critical to provide leadership, data surveillance, coalition-building, assessment, and planning. The grant's accomplishments helped elevate dental disease as an important public health issue through the completion and publication of the BSS survey of 3rd grade and Head Start children. More importantly, the grant helped build community capacity to support ongoing oral health work through the state and neighbor island coalitions. The coalition will continue to convene and coordinate the state's dedicated oral health stakeholders, community-based programs, and strong advocacy agenda.

FHSD will continue to support surveillance, prevention, and workforce development activities through its Office of Primary Care and Rural Health.

Challenges, Barriers

The primary barrier to progress will again be securing sustainable funding for SOHP staffing and operations. While FHSD continues to explore funding options to help support ongoing public health functions, little program activity is possible without dedicated staffing and resources. Thus, this priority was deleted as part of the 2020 Title V needs assessment.

Child Health - Application Year

NPM 6 - Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed screening tool

For the Child Health domain, Hawaii selected NPM 6 Developmental Screening as a continuing priority based on the 2020 five-year needs assessment. By July 2025, the state seeks to increase the percentage of children ages 9 through 35 months receiving a developmental screening to 45.0%. Plans to address this objective and NPM are discussed below.

Based on findings from the 2020 Title V Needs Assessment, Hawaii's Developmental Screening Workgroup will reconvene to assess the activities, using the strategies identified in the Policy and Public Health Coordination Scale. While most providers and families still believe developmental screening is a critical priority that the state needs to address, some of the activities may need to be reevaluated to assure Hawaii is achieving measurable impacts to assure healthy child development. Because of the COVID-19 pandemic, Hawaii will reassess developmental screening strategies and activities in the context of other critical needs of children and families and the course of the COVID virus as restrictions begin to ease.

Strategy 1: Systems Development

Hawaii will continue to work with partners to implement the statewide system for developmental screening, referral, and services. These efforts are part of the State Plan for Early Childhood that developed from the strategic plan for the federal Preschool Development Grant Birth through Five (PDG B-5). Community-level initiatives, such as the ECCS Impact grant focused on Maui County, will be used to inform statewide policies, procedures, and guidelines and will be shared with the Early Learning Board (ELB), Hawaii's governing board to the Executive Office on Early Learning (EOEL). Hawaii applied for and received the new iteration of the ECCS grant, focusing on promoting maternal and infant and child health and family well-being.

Strategy 2: Family Engagement and Public Awareness

Hawaii's ECCS grant will continue its parent engagement project through expanding to three new groups: Grandparents as primary care providers, Caregivers pregnant or with children up to one year old, and an all-inclusive Caregiver group. The CDC Act Early COVID-19 grant will be testing social media influencers to help promote developmental screening with families.

Strategy 3: Data Collection and Integration

Hawaii will continue to work within FHSD to analyze available data to better target outreach efforts among various communities. Collaboration with Hawaii's Med-QUEST Division will continue to determine data elements that can be collected and shared. The new ECCS systems-building grant will explore the adoption of more CMS MCH Core Quality Assurance measures that can be used to monitor need and target strategies to address health equity.

Strategy 4: Social Determinants of Health and Vulnerable Populations

The use of the Survey of Well-being of Young Children (SWYC) tool as a developmental screening, behavioral health screening, and family well-being screening of young children birth to age 5, will continue to be explored with partners to address the social determinants of health and identify vulnerable at-risk families that may be in need of resources. Pilot developmental screening projects with agencies/programs that work with vulnerable populations will be pursued and modified to reach families most in need. Hawaii received a CDC Act Early COVID-19 grant as part of promoting

the importance of developmental milestones. Hawaii CDC Act Early and the Children with Special Health Needs Branch will partner with WIC to implement the 2-year-old and 3-year-old developmental checklist to see if parents have any concerns about their child's development by completing the checklist. WIC staff will help with the warm hand off to Early Intervention if the child is younger than 3 or to Department of Education Preschool Special Education if the child is older than 3.

Strategy 5: Policy and Public Health Coordination

Hawaii will continue to implement the Public Health and Policy Rating Scale to track Title V-led activities around developmental screening. By working in all five areas, a better system of developmental screening will emerge, and more children and families will be supported. The FY 2021 objective is set for 27 out of the 30-point scale; however, progress may be affected by continued COVID pandemic impacts.

SPM 1 - Rate of confirmed child abuse and neglect cases per 1,000 children aged 0 to 5 years.

For the Child Health domain, Hawaii selected Child Abuse and Neglect (CAN) prevention as a continuing state priority based on the 2020 5-year needs assessment. By July 2025 the state seeks to reduce the rate of confirmed child abuse and neglect cases per 1,000 children aged 0 to 5 years, to 5.2. Plans to address this objective and SPM are discussed below.

Strategy 1: Support the collaboration and integration of family strengthening and child maltreatment prevention programs and activities across federal, state, and local and private programs and organizations.

Preventing CAN will continue to be addressed by the CANP program through established collaborations with private organizations, including the Early Childhood Action Strategy (ECAS), and Hawaii Children's Trust Fund (HCTF).

The ECAS Nurture Daily campaign will move into the next phase which will provide resources for families, other caregivers and community-based providers with new print and virtual materials and messaging products designed to promote serve-and-return theme.

The CANP Program Coordinator will support the HCTF Advisory Board, Advisory Committee, and Coalition with community grant-making opportunities to ensure community-level needs, concerns, and solutions are at the forefront in planning as well as execution of statewide CANP training and activities.

Existing collaborations with the Departments of Education (DOE), and Health (DOH) will continue to be expanded. Collaborative strategies with the DOE involve supporting the implementation of four pilots school-based Family Resource Centers and establishing and expanding the competencies of DOE staff in TIC practices under the Trauma Recovery Project.

An increasing body of evidence indicates that children are more likely to thrive with the support, guidance, and nurturing of both parents. Yet, many children across the country are growing up without fathers. The CANP Program will establish a new collaboration with the DHS Fatherhood Commission to support one or more of the Commission's statutory duties, such as raising public awareness, supporting fatherhood programs, and promoting more education to train and support fathers.

Strategy 2: Promote safe and nurturing relationships by raising community knowledge about resilience and adverse childhood experiences

Statewide, year-round community-level events and activities will be employed to increase awareness and knowledge of safe and healthy relationships and to promote family strengthening and community resiliency. Opportunities to collaborate with other health observances such as domestic violence prevention, Brain Awareness Month, Sex Assault Awareness Month, and Safe Sleep will be encouraged. Planning and implementation will be carried out in collaboration with existing child abuse/neglect prevention coalitions or other community groups. Events will be virtual and in-person as long as the most current County and State COVID-19 related policies are followed. Activities or events will be based on the Centers for Disease Control and Prevention Protective Factors.

MCHB Parenting Support Programs will continue to provide statewide outreach to parents, caregivers, the professional community, and community at-large. Services include a telephone warm-line, information on child development, and available community resources. Similarly, the Home Visiting (HV) Program will maintain its home-based visiting services to at-risk pregnant women and parents with young children. HV services will continue to use three evidence-based programs – Parents As Teachers (PAT), Healthy Families American (HFA), and Home Instruction for Parents of Preschool Youngers. PAT and HFA are listed as well-supported evidence-based models on the FFPSA Clearinghouse.

Strategy 3: Provide training and technical assistance to community-based, prevention-focused programs to strengthening families and prevent child abuse and neglect.

The CANP Program will serve as a resource for training and technical assistance opportunities offered by such organizations as the National Center for Community-Based Child Abuse Prevention, ACES Connection, Community Resilience Initiative, Children's Bureau Learning and Coordination Center, Center for the Study of Social Policy, Child Welfare Information Gateway, and FFPSA Clearinghouse. The CANP Program will also be a hub for data and information sources available via the National Survey of Children's Health, FrameWorks Institute, National Child Abuse and Neglect Technical Assistance and Strategic Dissemination Center, as well as the Centers for Disease Control and Prevention.

Individuals and organizations with firsthand knowledge of the cultures, values, and history of the different ethnic populations of Hawaii are extremely valuable resources to ensure the cultural lens of child abuse and neglect prevention is an integral part of the training and technical assistance activities. CANP Program will support learning opportunities addressing historical and cultural trauma experienced by Native Hawaiians and Pacific Islanders as well as the effects of trauma on special populations (military, children with disabilities, children and families experiencing incarceration or homelessness), building individual and community resilience, trauma-informed and trauma-responsive systems of care, protective factors and Standards of Quality for Family Strengthening and Support.

The CANP Program will partner with internal and external partners on other training topics as safe sleep, safe and effective discipline, and domestic violence. The Hawaii Home Visiting Program will continue to provide quarterly trainings to their contracted statewide service providers.

Strategy 4: Collaborate with the Hawaii Department of Human Services Primary Prevention Initiatives.

Strategy 4 was amended to broaden the collaboration with the DHS from a specific focus area, namely the FFPSA, to include a broader primary prevention approach. The federal Administration on Children and Family's new vision of

strengthening families through primary prevention of child maltreatment to keep children from entering the foster care system created an opportunity for the CANP Program to enter into a new level of collaboration with the DHS with more expertise and resources on the primary prevention of child abuse and neglect.

A new initiative will focus on designing an integrated prevention continuum of services, practices, and policies across the DOH and DHS, supporting families to provide safe, stable, nurturing relationships and environments for their children.

The CANP Program Coordinator will continue to serve as the CBCAP representative on the All State Team work on collaboration. The Team will start on implementing the pilot plan for Year 3 that will include the Oahu Zero To Three Specialty Court.

DOH collaboration will continue with the Family Strengthening and Violence Prevention programs in such efforts as public and private agency workforce development in ACEs, resilience, trauma-informed care, community building, incorporating violence prevention activities as appropriate, as well as awareness building.

Strategy 5: Promoting Health Equity by addressing disparities by addressing disparities in confirmed CAN cases.

The data from DHS CWS point to significant disparities among CAN confirmed cases, specifically by race and age. As previously noted, Native Hawaiians represent 40% of confirmed CAN cases for all age groups. Infants and toddlers represent nearly a third of confirmed cases. CANP will work with community organizations representing these priority populations to collaboratively review/understand the data and identify actions going forward to address these inequities. CBCAP funding available through the federal American Rescue Plan may be used to contract community organizations to promote evidence-based prevention strategies that focus on disparity populations.

SPM 5 - The percentage of Medicaid children receiving six or more well-child visits in the first 15 months of life

For the Child Health domain, Hawaii added this new state priority to promote child wellness visits and routine immunizations especially for young children. The priority is a result of ongoing needs assessment and concerns raised during the COVID-19 pandemic that many well-child visits and immunizations were postponed or delayed due to lockdowns and safety concerns.

By July 2025, the objective is to increase the percentage of Medicaid children receiving six or more well-child visits in the first 15 months of life. The measure is a Medicaid Core Child quality performance measure, which Hawaii is currently reporting and reflects Medicaid's partnership in this project.

Strategy 1: Collaborate with Pediatric Providers

- Collaborate with AAP-Hawaii Chapter leadership to develop messaging and campaign direction.
- Support AAP-Hawaii Chapter leadership development to support speakers and champions for the pediatric community. Because Hawaii has a diverse community, there may be doctors or spokespeople of different nationalities or populations to help deliver the trusted messages.
- Continue to work with AAP-Hawaii Chapter on other medical home messaging or COVID-19 information dissemination.

Strategy 2: Conduct Public Awareness Campaign

- Develop with partners campaign message and timeline
- Develop website and promotional toolkit for pediatric and family service providers
- Develop evaluation metrics and data outputs and outcomes to determine the success of the campaign
- Conduct the campaign and measure effectiveness of messaging

Strategy 3: Build Capacity for Pediatric Champions

Hawaii recognizes that some children are seen by family physicians of other healthcare providers and that it is important to have trusted pediatric champions to help inform the public and parents about the important health messages. Hawaii's Title V agency may be able to use some resources to help support other pediatric champions to help advocate and educate on behalf of their profession.

- Develop list of speakers for speakers' bureau or media opportunities.
- Work with AAP-Hawaii Chapter to augment resources if needed for other media campaigns and opportunities to promote pediatric champions.
- Continue to promote collaboration with healthcare providers, insurers, and other critical partners including families.

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

There are no plans for NPM 13.2 since the priority was not selected by the 2020 Hawaii needs assessment for continuation due to the lack of program resources.

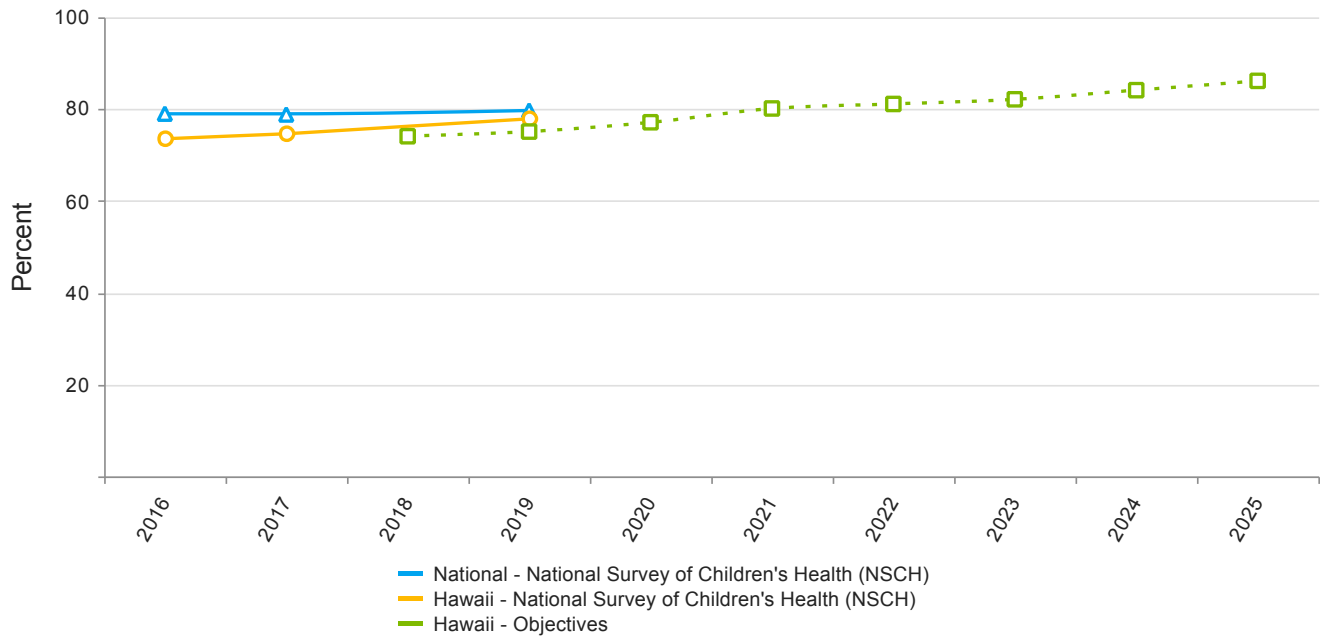
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	31.0	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	6.5	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	10.4	NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	18.6 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	56.6 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	92.9 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2018_2019	11.1 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	10.7 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2019	16.4 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	67.0 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	79.4 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	83.4 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	82.5 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	15.7	NPM 10

National Performance Measures

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. Indicators and Annual Objectives



Federally Available Data

Data Source: National Survey of Children's Health (NSCH)

	2016	2017	2018	2019	2020
Annual Objective			74	75	77
Annual Indicator		73.5	74.6	74.6	77.7
Numerator		67,325	74,226	74,226	76,702
Denominator		91,592	99,470	99,470	98,664
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives

	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	81.0	82.0	84.0	86.0	87.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Develop and disseminate a teen-centered, Adolescent Resource Toolkit (ART) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits

Measure Status:			Active
State Provided Data			
	2018	2019	2020
Annual Objective			18
Annual Indicator			
Numerator	9	13	18
Denominator	30	30	30
Data Source	ART and Science Workgroup	ART and Science Workgroup	ART and Science Workgroup
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	23.0	25.0	28.0	30.0	30.0	30.0

State Action Plan Table

State Action Plan Table (Hawaii) - Adolescent Health - Entry 1	
Priority Need	
Improve the healthy development, health, safety, and well-being of adolescents	
NPM	
NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	
Objectives	
By July 2025, increase the percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year to 84%	
Strategies	
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 services.	
Workforce Development. Provide resources, training, and learning opportunities for adolescent caregivers, community health workers, and other service providers to promote teen-centered, annual wellness visits.	
ESMs	Status
ESM 10.1 - Develop and disseminate a teen-centered, Adolescent Resource Toolkit (ART) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

Introduction: Adolescent Wellness Visits (AWVs)

For the Adolescent Health domain, Hawaii selected NPM 10 (preventive medical visits) based on the results of the 2015 five-year needs assessment.

Data: The 2020 Title V state objective is to increase percent of adolescents with a preventive medical visit in the past year to 77.0%. Data from 2019 show that Hawaii (77.7%) met the 2020 state objective (77.0%) and was similar to the national estimate of 79.6%. The Hawaii estimate has met the related Healthy People 2020 Objective (75.6%). There was no significant differences in the subgroups based on 2019 data due to the small sample size.

The 2019 Hawaii Youth Risk Behavior Survey (YRBS) showed a 1.9% decrease in preventive visits of high school teens who reported seeing a doctor for a check-up or preventive physical exam, going from 65.9% in 2017 to 64.0% in 2019. These numbers may be overstated if adolescents defined sports physicals as a wellness visit. Neighbor island disparities remain. Kauai County high school youth reported the lowest percentages of adolescent wellness visits, followed by Maui County and Hawaii County.

Objectives: Based on the 2020 needs assessment, this NPM will be continued into the 2021-2025 plan period. The data for NPM 10 did not see a significant increase in wellness visits over the past five years. Reviewing the baseline data and the HP 2030 objective, the state objectives through 2026 have been updated to reflect an approximate 10% improvement over five years

Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they are expected to assume individual responsibility for health habits. In particular, adolescents with chronic health problems take on a greater role in managing those conditions. Adolescence is a critical time to empower, educate, and engage teens to establish health behaviors that will lay the foundation for their health into adulthood.

Nationally, Adolescent Wellness Visits (AWV) are recognized as an important standard of care. The American Academy of Pediatrics' (AAP) *Bright Futures* guidelines recommend that adolescents have an annual checkup starting at age 11. The visit should cover a comprehensive set of preventive services, such as a physical examination, discussion of health-related behaviors, and immunizations.

Title V Lead/Funding: The Title V Adolescent Health Unit (AHU) in the Maternal and Child Health Branch (MCHB) is the lead for the AWV measure. The AHU also administers the federal Personal Responsibility Education Program (PREP) grant and assists with management of state-funded Perinatal Support Services (PSS) contracts. The AHU coordinator is partially Title V funded.

Strategies/Evidence: The strategies for this measure are based on guidelines from the national Office of Adolescent Health's Think, Act, Grow (TAG) Call to Action designed to promote adolescent health through a comprehensive approach working with varied stakeholders. The strategies are:

- Collaboration. Develop partnerships with community health and youth service providers to promote adolescent wellness visits.
- Engagement. Work with adolescents/youth service providers to develop and disseminate informational resources.
- Workforce Development. Provide resources, training, and learning opportunities for adolescent caregivers,

community health workers, and other service providers to promote adolescent wellness visits.

Research provided by AMCHP and the MCH Evidence Center were reviewed to identify additional evidence for Hawaii's strategies. AHU is using several strategies recommended by the National Adolescent and Young Adult Health Information Center and cited in the evidence-based literature. These include building collaborative networks with agencies and institutions at the systems level, building capacity in communities to reach youth-serving professionals, parents, guardians, and other caring adults to engage adolescents to share their voice and help us to shape the ways they access and receive information of interest and of concern to them. The MCH Evidence Center acknowledges this ESM as an 'innovative tool' to track AWV efforts.

Coordination with NPM 12: Transition to Adult Health Care

AHU is coordinating efforts with the Children with Special Health Needs program to address NPM 12 since it also impacts youth with and without special needs to promote transition to adult care and overlaps with NPM 10 AWV activities.

COVID Impacts: The COVID-19 pandemic drastically reduced preventive care services as healthcare providers struggled to access personal protection equipment (PPE) and implement evolving safety protocols as information about the virus became available. Many doctors' offices temporarily closed and limited care to critical/emergency conditions. Routine healthcare and preventive services like AWVs and vaccinations were largely postponed through FY 2020 with the closure of non-essential businesses, schools, and childcare facilities. And for some families, priorities shifted to more immediate needs (income/housing stability and educational/childcare responsibilities). Many families remained reluctant to return to in-person healthcare visits as restrictions eased somewhat and preventive visits may have been difficult to schedule as provider offices addressed a backlog of cancelled appointments and saw fewer clients due to COVID safety protocols. Existing disparities related in accessing preventive healthcare that existed prior to the pandemic may have only worsened among Hawaii's adolescents.

Strategies to address the NPM for adolescent preventive visits are discussed below.

Strategy 1: Collaboration. Develop partnerships with community health and youth service providers to promote adolescent health and annual wellness visits

The Title V AHU continued to build partnerships with community health and youth service providers to promote adolescent health and wellness visits; however, some activities were reduced and changed due to the pandemic.

AHU strategically leveraged the partnerships with community-based service providers who work with youth directly to collect input from the teens they serve on the effects of the pandemic and their physical, social, emotional, and mental well-being. AHU used the input to develop effective messaging and provided insight for workforce training ideas that strengthened their relationships with and resources for teens and young adults through the pandemic.

PREP: Since 2017, the Hawaii National Guard Youth Challenge Academy (YCA) is the state's primary PREP provider. YCA staff use the evidence-based Teen Outreach Program® (TOP®) curriculum in their Hawaii Island and Oahu residential facilities. YCA targets youth who are at high risk for substance abuse, teen pregnancy, delinquency, and criminal activity. The teens voluntarily enroll in the alternative, quasi-military school. Consistently, 94% of their 250 participants, 16 to 18 years of age, complete the positive youth development and teen pregnancy prevention TOP curriculum.

YCA participants provided valuable information on their knowledge of AWV, health topics of interest, and preferred

methods of receiving health information. The input was used to develop an Adolescent Resource Toolkit (ART) intended for teens, their families, and providers. Information on AWW was also integrated into the TOP curriculum and program evaluation.

In January 2020, AHU contracted with a second PREP provider, the Hawaii Youth Correctional Facility, known as the Kawaihoa Youth and Family Wellness Center (KYFWC). KYFWC is administratively attached to the state Department of Human Services, Office of Youth Services (OYS). The program is a residential facility of “last resort” for more than 30 court-involved youth 16 to 18 years of age from across the state. KYFWC is now implementing the TOP curriculum.

KYFWC youth correction officers (YCO) were trained by AHU to deliver TOP interactive lessons, lead discussions, and design a community service-learning project. KYFWC facilitators used the “Footsteps to Transition” infographic developed by the CSHN Branch to begin conversations about AWW and scheduling a doctor’s appointment. While many teens have health insurance, most did not know the insurer, have their insurance card, or made a doctor’s appointment.

KYFWC administration reported a significant change in the relationships between the residents and YCOs as a result of the TOP program. TOP follows a new ‘restorative justice’ approach used by KYFWC to reform discipline and problem-solving practices. AHU continues to provide technical assistance. Because PREP providers are residential programs, services continued through the pandemic with in-person classes.

PSS Contracts: AHU also partnered with the state-funded Perinatal Support Services (PSS) program providers to expand outreach efforts to high-risk youth. Most of the providers are FQHCs and several are located on the neighbor islands where teens have the lowest rates of AWW. The shelter-in-place and stay-at-home orders diminished the outreach efforts of community health workers (CHWs) to reach youth in the various counties. With school closures and the economic shutdown, healthcare was limited to identifying, treating, and mitigating COVID-19. Many of the PSS program outreach staff were furloughed leaving the neighbor islands with minimal adolescent health wellness visit activity. AHU has remained in contact with the adolescent outreach workers via a listserv to keep them informed on self-care, adolescent resources and tools, and adolescent health training opportunities.

Community-Based Organizations: During the pandemic, AHU strengthened connections with the state’s youth-serving organizations to promote healthy relationships, adolescent health and wellness visits, and connections with caring adults through virtual meetings and webinars. Partners included: the Hawaii Youth Services Network, Office of Youth Services, Coalition for a Drug-Free Hawaii (CFDH), Hawaii Partnership to Prevent Underage Drinking, Youth Tobacco prevention coalition, DOH Chronic Disease School Healthy program, Prevent Suicide Hawaii Taskforce (PSHT), Mental Health America of Hawaii, After School Program Alliance, and Atherton Young Men’s Christian Association.

AHU continued working with the CSHN program to incorporate transition planning into the adolescent health training activities.

AHU participates in the Hawaii Health Survey committee, which consists of representatives from the Department of Education, University of Hawaii, Office of Hawaiian Affairs, and DOH Chronic Disease School Health program. The Committee provides oversight for the YRBS, which is administered in odd-numbered years and includes an AWW question, “When was the last time you saw a doctor or nurse for a check-up or physical exam when you were not sick or injured?”

Strategy 2: Engagement. Work with adolescents and youth service providers to develop and disseminate

informational resources to promote access to adolescent preventive health services

ART remains AHU's primary vehicle for information dissemination to the community. ART focuses on building adolescent knowledge, behavior, and skills to access healthcare and community resources. Using ART, health educators and outreach staff are able to share/connect teens to services or healthcare.



Youth Input: In the spring of 2020, teens and young adults from the Coalition for a Drug-Free Hawaii's (CDFH) TeenLink Hawaii program developed a health and wellness survey and engaged about 140 of their peers across the state to share their knowledge and attitudes about AWWs using information from ART.

Only 4.94% of the respondents did not believe an AWW was important, citing barriers like health insurance and additional out-of-pocket costs. The other 95% noted the benefits of an AWW: knowing your health status and learning ways to improve health. Doctors were

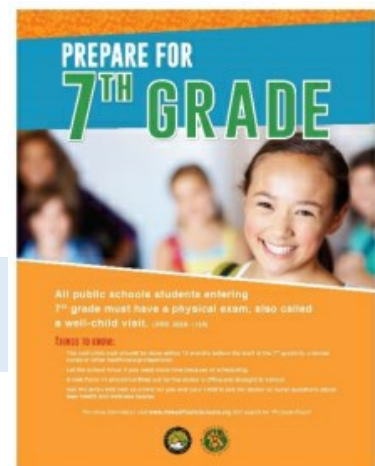
recognized for identifying health issues/chronic conditions that may need monitoring. When asked about who they seek health advice from, 83% responded their mother first, father second, and physician third. Students reported the best ways to get reliable and helpful health information: doctors, parents, Google search, and websites.

The CDFH teen and young adult volunteers held a Zoom workshop for 40 service providers to showcase the one-stop, adolescent-centered TeenLink Hawaii website for teens, young adults, caregivers, and the community. The tools, resources, and messages were put together by teens for teens and were vetted by the CDFH staff. ART also includes information adapted from the CSHNB transition materials to increase adolescents' confidence to access healthcare services and strengthen independent life skills.

AHU continues to support DOH's Chronic Disease and Health Promotion Division (CDHPD) campaign about the physical examination requirement for all public school youth entering the 7th grade. Prior to the pandemic, information on the policy is included in ART. The CDHPD messaging campaign to youth and families continued in partnership with the Department of Education (DOE), in the form of public service announcements played through various media channels. CDHPD reported that of the 13,140 public school teens who entered the 7th grade in the 2019-20 school year, 6,456 (49.1%) received physical exams. This was a 0.2% decrease from the previous year (49.3%).

Strategy 3: Workforce Development. Provide resources, training, and learning opportunities for youth service providers and community health workers to promote adolescent health and wellness visits

AHU provides training and technical assistance (TA) on adolescent health and positive youth development for youth and other service providers. AHU continues training on positive youth development and protective factors as part of the PREP program. During the pandemic, AHU continued to provide staff development webinars and online training opportunities.



teenLink Hawaii TeenLink Hawaii (TLH) is the "go-to" website for health and wellness tools and resources complete with Instagram Posts, IGTV Videos, TikToks, YouTubes, print resources, infographics, and more. It's by teens and for teens, their caregivers, and youth service providers. On a

quarterly basis, AHU sends the recorded introduction to TeenLink Hawaii workshop to neighbor island agencies. CSHN's neighbor island staff utilize TLH and their transition to adult healthcare information that was incorporated into the website. A resiliency media campaign is in motion to publicize, recommend, and refer teens and young adults to the TLH website and social media. The goal is also to reach more adolescents, parents, and youth serving providers, agencies, and institutions to access the self-help and self-care tools, resources, and services. ART, renamed by the teens to the Health and Wellness Toolkit, includes a push for the AWW.

Evidence-Based/Informed Strategy Measure

The Evidence-Based/Informed Strategy Measure (ESM) selected for adolescent wellness is ESM 10.2 Develop and disseminate a teen-centered Adolescent Resource Toolkit (ART) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits. The measure uses a scale to track progress on the development and dissemination of ART. Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 30. Scoring is completed by Title V AHU staff with input from key stakeholders.

Despite the pandemic, the 2020 indicator is 20 out of 30 points (66%), an increase over 2019 since major progress was achieved working directly with youth to assess, revise, and promote the ART via TeenLink. Objectives have been set through 2026. The most current data collection form is below.

ESM 10.2 – Develop and disseminate a teen-centered Adolescent Resource Toolkit (ART) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Annual Objective			N/A	N/A	20.0	23.0	25.0	28.0	30.0	32.0
Annual Indicator			9	13	20					

Element	0 Not met	1 Partially met	2 Mostly met	3 Completely met
Strategy 1: Collaboration				
1. Utilize partnerships with youth servicing programs to promote AWW and adolescent health including AHU service contractors, other Title V and DOH programs, community coalitions, and organizations.			X	
2. Introduce CSHN's "Footsteps to Transition" to contractors and outreach staff to utilize the infographic to show participants where they are in their transition to adulthood and to direct the warm handout conversation to the topic area needed.			X	
3. Update the listserv of adolescent health stakeholders and if available, collect adolescent developed information for incorporation into the ART.			X	
4. Develop a local base of speakers on issues affecting adolescent behaviors.		X		
Strategy 2: Engagement: Adolescent Resource Toolkit (ART)				
5. Promote the TeenLink Hawaii website as the "teen and young adult go to site" for teen-centered resources, tools, and services, which includes the Footsteps to Transition and other ART materials developed by teens and young adults.			X	
6. Conduct assessments to determine adolescent awareness of the AWW and the perceived barriers to accessing an AWW.			X	
7. Assess service provider and informant information to assure the ART will provide useful health and resource information that will meet the needs of adolescents.			X	
Strategy 3: Workforce Development Training for Community Stakeholders				
8. Maximize opportunities to inform internal direct service providers and community stakeholders regarding AWW visits, the warm hand-out strategy, and the ART.			X	
9. Utilize the listserv to inform the work of lead adolescent health advocates regarding webinars, in-person training opportunities, and other adolescent resources to include: positive youth development, teen pregnancy prevention, mental health first aid, gender orientation, and the benefits of AWWs.			X	
10. Assess stakeholders for increased knowledge and comfort level post training.			X	
Total Points	20			

Current Year Highlights for FY 2021 through June 2021

Here are some highlights of current adolescent health activities for FY 2021, including continued impacts and changes from the COVID pandemic in Hawaii.

The COVID pandemic emergency orders and vaccinations have resulted in relaxing of restrictions from a year ago. Based on a TLH survey of Hawaii youth, the negative impacts on adolescent health included: school closures, adjustments to distance learning, unsuitable work space at home due to overcrowding, the lack of in-person socializing with their friends, and sleep loss due to stress over school work and grades.

Physician shortage: Hawaii's continuing physician shortage was also exacerbated by the COVID-19 crisis, which may impact accessibility of AWW providers. A 2020 assessment of primary care physicians by the University of Hawaii reported the pandemic disrupted their practice with temporary and permanent clinic closures, early

retirement, increased telehealth practice, altered operating hours and locations, and reduced patient volume. Primary care doctors represented the largest shortage on all islands.

PREP: In early 2021, RYSE (Residential Youth Services and Empowerment) began implementation of the Teen Outreach Program® (TOP®) to the 18- to 24-year-old young adults at four sites. Two staff workers are certified TOP trainers and will train more of their staff to facilitate classes at their other shelters. More than 50 young adults will receive the positive youth development and teen pregnancy prevention curriculum each year. RYSE's program assists their residents in obtaining health insurance and provides transportation when possible to clinic visits.

The Kawaihoa Family and Youth Wellness Center (KFYWC) youth correction officer (YCO) training coordinator informed the correctional facility warden of a positive change in the climate and culture of the facility and adolescents as a result of TOP and other staff development training offered through AHU. Each teen receives a physical assessment from the facility physician upon entry to the facility. AHU continues to work with the YCO training coordinator for more information on the healthcare services provided to the 30 KFYWC teens.

The Hawaii National Guard Youth Challenge Academy (YCA) will continue to implement TOP at their residential facilities on Oahu and Hawaii Island and serve 300 high school dropouts, 16 to 18 years of age. Since teens are required to have a physical upon entry to YCA, AHU will expose staff facilitators to the TLH website and ART to incorporate into the interactive lessons.

Coalition for Drug-Free Hawaii (CDFH) updates: The CDFH Assessment/Planning Report noted that more resources and support for mental health issues like depression, how to manage stress, and the importance of sleep were needed for youth. Social media was reported as the best way to meet the need for easier access to health information. Anonymous online access with ease of use was cited as highly desired and a secure website where questions can be asked and answered anonymously was also suggested. Teens also cited other modes of information that are useful from classes to resources in the school, email, and special events. While there is not a single mode of communication that is needed, data suggests that a multipronged approach from which teens are able to select information for themselves and others works best.

The CDFH youth leadership groups continue to maintain and update the TLH website. The website monthly hits have tripled since a February 2021 presentation to promote the resource. The top topics visited: Coronavirus, Suicide, Mental Health, Health and Wellness Toolkit, Youth Leadership, Sexual Violence, Go Green, Club Drugs, Alcohol, and Runaway.

Implementation of COVID-19 stay-at-home orders and subsequent school closures statewide required substantial pivots for AHU, given that many of its usual activities involve working with the providers that engage with youth.

Activity highlights:

- Public service announcements released aimed at adolescents and their families regarding staying connected with family, keeping kids busy/family activities, and tips for healthy relationships.
- CDFH to provide adolescents and their families with additional information on programs and resources via the TeenLink Hawaii (TLH) program, complete with social media accounts and an interactive website.
- The AHU listserv was used to provide information on webinars and adolescent-centered training opportunities to its youth service providers.
- In response to families delaying healthcare visits, the DOH Immunization program issued a press release encouraging parents to schedule back-to-school vaccination and physical examination appointments as services started to reopen in June.
- A new partnership with Atherton YMCA provided AHU with a network of 18-to-24-year-old college students to

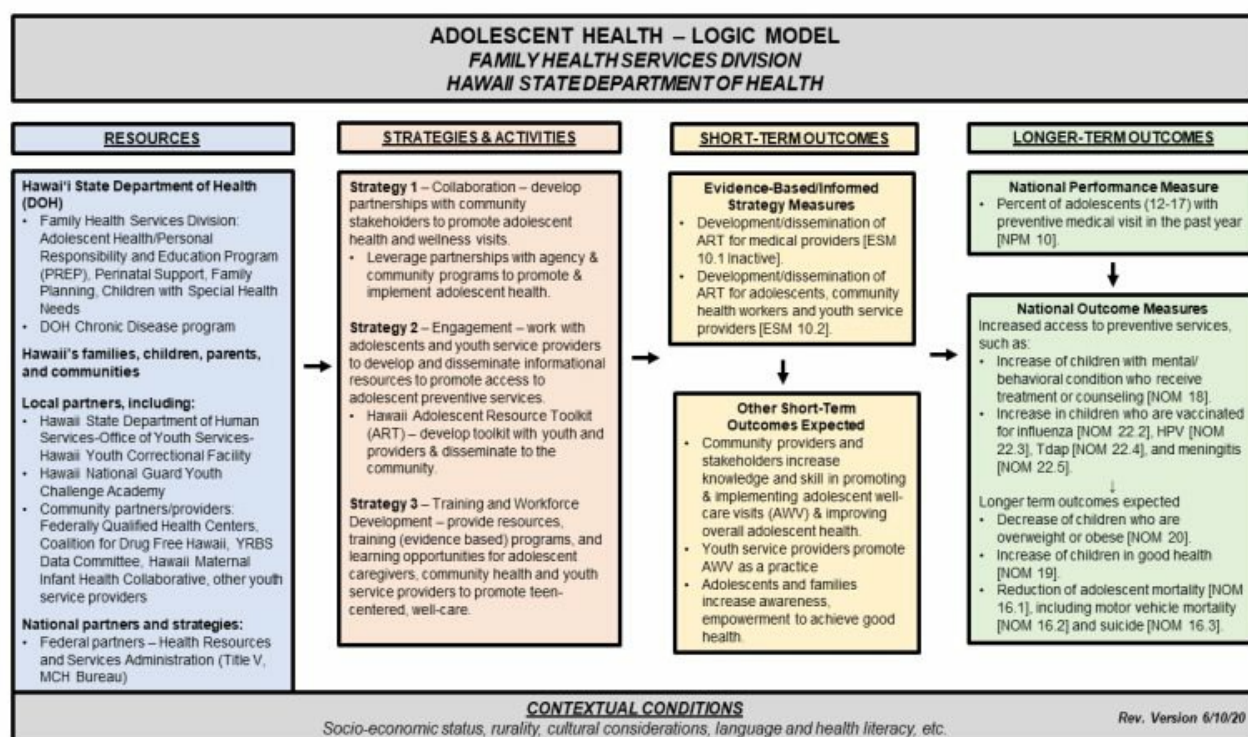
tap into for input to inform outreach efforts.

Review of the Action Plan

A logic model was developed for NPM 10 to review alignment among strategies, activities, measures, and desired outcomes. By reworking the three strategy areas, Hawaii will promote adolescent preventive medical visits.

Short-term outcomes for the strategies include:

- Increased knowledge and skill among community youth service providers to promote and assist with scheduling adolescent well-care visits and support overall adolescent health.
- Increased awareness and empowerment among adolescents and their families in achieving good health.



Challenges, Barriers

AHU's ART aims to promote positive health behaviors including self-care and lifestyle factors; encourage youth to take greater responsibility for their health decisions; provide teens with information they need to connect with their personal physicians; develop the ability to schedule well-visits; and link youth to health services (e.g., AWWs) and resources.

Despite ongoing promotion of AWWs throughout the state, AWWs are not increasing. New challenges were brought on by the pandemic including a shortage of primary care physicians across the state and a change in healthcare delivery where office visits are limited to illnesses. The usual barriers also persist that doctor visits are for illnesses only or preventive visits require out-of-pocket costs and that sports physicals are the same as an AWW. New players in the healthcare market like 'minute clinics' and urgent care centers also pose challenges to AWWs. Busy families use these convenient community-based options as a primary source of care, which can undermine the benefits of the more comprehensive AWW provided by a medical home.

Currently, the COVID-19 pandemic presents new challenges to the in-person comprehensive wellness office visit because of social distancing guidelines and the loss of employer paid health insurance for families affected by the increasing unemployment crisis. Many families may elect to postpone preventive health visits and vaccinations or opt for less comprehensive telemedicine options.

Overall Impact

Over the past five years, the strategies for this measure changed significantly when a key partnership with medical providers no longer proved a viable option. Focusing on program assets and strengths, AHU utilized its PREP and PSS contracted providers to develop educational resources and messaging. AHU also worked with its network of youth service providers for additional input and to assist with dissemination of adolescent health education.

Perhaps, AHU's greatest success is with youth engagement. AHU's commitment to engage youth in the assessment of their health concerns and development and dissemination of health education and messaging has culminated in youth-designed information via the state TeenLink website and social media.

Another success is the partnership with CSHNB to coordinate AWW and transition messaging was also completed through participation in an MCH ad hoc cohort.

Because the current PREP program sites are both residential, the TOP 'social club model' was readily accepted by teens and staff and easily implemented as a mandatory extracurricular activity since youth were housed for more than six months at a time. Program directors were receptive to new approaches/curriculum since their internal program resources were so limited. Partnering with programs administered by state agencies also simplified contracting. The residential programs were also largely unaffected by the COVID lockdowns/restrictions.

Lastly, AHU's continued work with high-risk youth through PREP reflects its commitment to address health equity issues. The three PREP sites serve some of the state's most at-risk youth populations, using evidence-based programs to promote adolescent health and wellness visits. In the FY 2022 plans, AHU will address the disparities illuminated by the COVID pandemic with projects focused on targeting Native Hawaiians and Pacific Islanders.

Adolescent Health - Application Year

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

For the Adolescent Health domain, Hawaii selected NPM 10 Adolescent Preventive medical visits as a continuing priority based on the 2020 five-year needs assessment. By July 2025, the state seeks to increase the percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year to 84%. Plans to address this objective are discussed below.

Moving forward, the Adolescent Health Unit (AHU) strategies will continue as:

- Collaboration. Develop partnerships with youth service providers to promote adolescent health and annual wellness visits (AWV).
- Engagement. Establish working relationships with service providers with access to adolescents and young adult groups to inform the development of relevant information tools, services, and resources needed; provide insight on the ways information is sought and received; assist in promoting self-care; and accessing 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.

In addition, a new strategy has been added to address health equity.

Strategy 1: Collaboration. Develop partnerships with community health and youth service providers to promote adolescent health and annual wellness visits

The Title V AHU will continue to build partnerships with community health and youth service providers that work with groups of teens and/or young adults on a routine basis to promote adolescent health and wellness visits.

AHU will continue work with providers funded through its federal Personal Responsibility and Education Program (PREP) and Perinatal Support Services (PSS) programs to reach high-risk youth. Although the PSS program has been revised to integrate reproductive health services, the established PSS provider partnerships will continue. Activities include working with outreach workers to promote AWV and adolescent health through school and community venues depending on COVID-related circumstances.

Collaboration will continue with other youth-serving programs, including the Title V CSHN, Department of Health Chronic Disease School Health Program, DOE's health education resource teachers, and other community-based organizations.

Specific activities planned to promote adolescent health and wellness visits for the coming fiscal year include:

- Develop partnership opportunities to broaden access to youth-serving programs/organizations and health clinics, especially on the neighbor islands.
- Update the listserv of adolescent health stakeholders to share staff development training opportunities, and resource materials that may also be incorporated into the TeenLink Hawaii one-stop website and continue the support and promotion of the adolescent resources and tools.
- Develop and maintain a list of online training, certifications, and other professional development classes available to the community on issues affecting adolescent behaviors.

Strategy 2: Engagement. Work with adolescents and youth service providers to develop and disseminate to promote access to preventive health services

The Title V AHU will continue to partner with adolescent-serving organizations to develop innovative outreach methods with input from teens and young adults. The CDFH teen leadership groups will use findings from their peer survey research to develop and maintain the teen-driven TeenLink Hawaii website and the Health and Wellness Toolkit (HWT) formerly known as ART. The teen groups will also identify the effective media platforms, designs, and tools to engage peers on health matters and disseminate information on AWVs. This input will be critical given the continued social distancing/isolation resulting from COVID-19 restrictions.

The teen groups will also assist with presenting HWT information to peers, families, and other youth organizations. HWT information will be included on CDFH's TeenLink Hawaii website that already contains national and local online information, service resources, and a variety of teen-centered materials.

Other activities planned for the coming fiscal year include:

- Engaging other youth groups to utilize and share the CDFH HWT materials through other community-based agencies and organizations and include the HWT in PREP program sites.
- Collect evaluation comments on HWT from both adolescents and service providers.
- Develop a young adult section on the TLH website for those 18 to 24 years of age.

AHU will also work with the CSHN Branch to engage Youth with Special Health Needs and their families to provide input on the new HWT. Possible avenues for input include a virtual townhall meeting for CSHN program's Transition to Adulthood stakeholders as determined by the CSHN/AHU adolescent health team.

Strategy 3: Workforce Development. Provide resources, training, and learning opportunities for youth service providers and community health workers to promote adolescent health and wellness visits

AHU will continue to provide adolescent health training and other technical assistance to PREP grant sub-awardees that facilitate the TOP curriculum at the Hawaii National Guard's Youth Challenge Academy (YCA), the Kawaihoa Youth and Family Wellness Center (KYFWC), RYSE (Residential Youth Services and Employment), and to the neighbor island health center outreach workers. Adolescent health training youth-serving providers will include topics that support healthy relationships; adult-to-teen communication skills such as motivational interviewing techniques; gender identification and orientation; and trauma-informed care.

Specific activities planned for the coming fiscal year include:

- Maximize opportunities to collaborate with Title V service providers and community stakeholders regarding AWVs and use of the HWT.
- Continue providing training on positive youth development, teen pregnancy prevention, mental health first aid, gender orientation, and the benefits of AWVs to service providers through webinars and other training opportunities.
- Solicit input from stakeholders on topics of interest and new methods for training delivery.
- Encourage the recruitment of TOP graduates to become facilitators and teen pregnancy prevention supports on their island of residence.

The ESM 10.2 Data Collection Form that lists 10 strategy implementation components will be completed and the indicator reported for next year.

Strategy 4: Develop self-help resources, tools, and services for Pacific Islander teens and young adults and all other Hawaii young adults to address health disparities

AHU will continue partnering with the Domestic Violence Action Center (DVAC) to reach out to their networks of Pacific Islander teens and young adults to assess their health and wellness needs. These young people will also assist in the development of resources, tools, and services (RTS) and will also identify the most effective media platforms, designs, and tools to engage their Pacific Islander peers on health matters and AWWs. This input will be critical given the continued implementation of COVID-19 social distancing guidelines and revised rules pertaining to school openings in the fall.

The DVAC youth groups will also assist with presenting the RTS information to peers, families, and other youth organizations. RTS will be housed on DVAC's website and digital platforms and will also be included on CDFH's TeenLink Hawaii website via a link to DVAC.

Title V Adolescent Health Programs

Adolescent Health programs under the Hawaii Title V program include some aspect of adolescent health.

Adolescent Wellness: Spans across the physical, mental, and social emotional aspects of adolescents and young adults 10 to 24 years of age. Concentration on high school graduation, sexual health, positive youth development, and transitioning into adulthood.

Personal Responsibility Education Program (PREP): The purpose of the grant is to fund the implementation of evidence-based positive youth development programs that broadens the cognitive context of abstinence and contraception for the prevention of pregnancy, sexually transmitted infections, and HIV/AIDS, which includes decision-making, self-regulation, and other adulthood preparation subject areas. This program targets services to high-risk, vulnerable, and culturally underrepresented youth populations between the ages of 10 and 24. Hawaii funds are used to implement the Teen Outreach Program (TOP) curriculum at the Youth Challenge Academy residential on facilities on Oahu and Hawaii island, and the Kawaihoa Youth and Family Wellness Center (formerly known as the Hawaii Youth Correctional Facility). Both facilities serve higher risk youth.

Child Abuse and Neglect, Domestic, and Sexual Violence Prevention: These programs are committed to the primary prevention of all forms of violence and stopping violence before it begins so that all people, families, and communities are safe, healthy, and free of violence. Together known as the Family Strengthening & Violence Prevention Unit, staff and partners provide programs statewide for the prevention of child abuse and neglect, sexual violence, and domestic violence. Activities also include support for parents and provision of education targeted for teens to prevent sexual violence.

Child Death Review: Statewide surveillance system for deaths among children ages 0-18 years. Aims to reduce preventable deaths to infants, children, and youth through multidisciplinary interagency reviews.

Children and Youth with Special Health Needs: Provides assistance with service coordination, social work, nutrition, and other services for children/youth with special healthcare needs, ages 0-21 years, with chronic medical conditions. It serves children/youth who have or may have long-term or chronic health conditions that require specialized medical care and their families.

Maternal Mortality Review: Statewide maternal mortality surveillance reviews that identify gaps in the healthcare system and social services; challenges with healthcare access and quality (especially prenatal and perinatal care); and ways to improve the health, health behaviors, and healthcare of women before and during pregnancy.

Family Planning Services: Assists individuals in considering the number and spacing of their children and promotes positive birth outcomes and healthy families. Education, counseling, and medical services are available through federal- and state-funded clinical programs including programs targeting adolescents. The program provides leadership for the implementation of One Key Question® (OKQ) – “*Would you like to become pregnant in the next year?*” OKQ supports reproductive life planning, decreases unplanned pregnancies, and promotes healthy birth outcomes.

Perinatal Support Services: Community health clinics statewide provide case-managed support services and resources for high-risk pregnant women and teens to increase the likelihood of positive birth outcomes. Objectives include: increasing annual wellness visits; early prenatal care; decreasing incidence of preterm, low, and very low birth infants; and improving the health of participants.

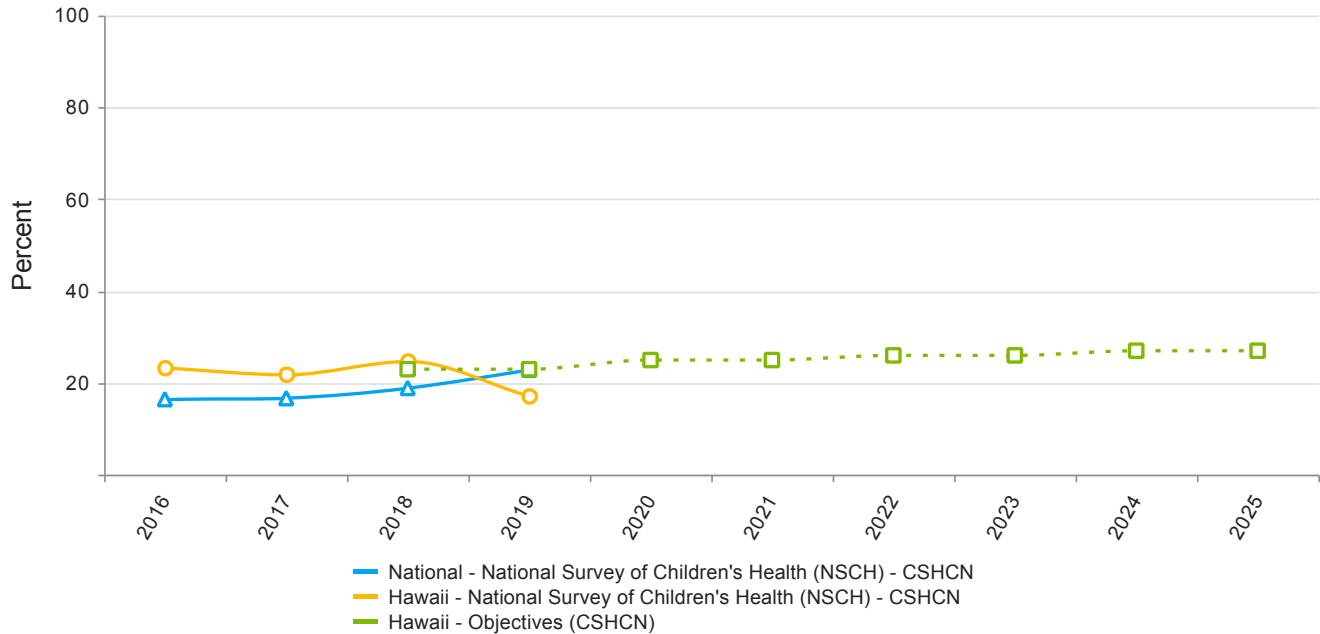
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	18.6 %	NPM 12

National Performance Measures

NPM 12 - 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 Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	2017	2018	2019	2020
Annual Objective			23	23	25
Annual Indicator		23.3	21.9	24.7	17.1
Numerator		4,235	4,457	5,037	3,214
Denominator		18,144	20,375	20,412	18,758
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	26.0	26.0	27.0	27.0	28.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - 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.

Measure Status:				Active	
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			17	21	24
Annual Indicator					
Numerator	12	13	18	22	27
Denominator	33	33	33	33	33
Data Source	Title V Transition Workgroup	Title V Transition Workgroup	Title V Transition Workgroup	Title V Transition Workgroup	Title V Transition Workgroup
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	26.0	28.0	30.0	33.0	33.0	33.0

State Action Plan Table

State Action Plan Table (Hawaii) - Children with Special Health Care Needs - Entry 1

Priority Need

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

NPM

NPM 12 - 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

Objectives

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%

Strategies

Incorporate transition planning into Children and Youth with Special Health Needs Section (CYSHNS) service coordination for CYSHNS-enrolled youths 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.

ESMs

Status

ESM 12.1 - 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.

Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NPM 12 – Percent of adolescents with and without special healthcare needs, ages 12 through 17, who received services necessary to make transitions to adult healthcare

Introduction: Transition Planning

For the Children with Special Health Care Needs (CSHCN) population domain, Hawaii selected NPM 12 Transition to Adult Health Care based on the results of the five-year needs assessment. By July 2020, the state sought to increase the percentage of youth who received transition services to 25% for youth with and without special healthcare needs.

Data: Aggregated 2018-2019 data show that the Hawaii (17.1%) did not meet the 2020 state objective (25.0%) but was similar to the national estimate of 22.9% for youth with special healthcare needs. Hawaii did not meet the related HP 2020 objective (no age range specified) to increase the proportion of youth with special healthcare needs engaged in transition planning with a healthcare provider to 45.3%. The estimates for Hawaii (18.5%) and the nation (16.9%) were not statistically different. There were no significant differences in subgroups by household income poverty level, nativity, race/ethnicity, sex, and household structure based on the 2018-2019 data provided.

Objectives: Based on the 2020 needs assessment, Hawaii will continue with transition to adult healthcare as a priority for youth with and without special needs. A review of the data for NPM 12 shows a significant improvement in transition planning for adolescents in general but not for CSHCN. The state objectives through 2026 have been updated to reflect a 10% improvement over five years. The related HP 2030 objective for this measure is under development.

Optimal health and adequate healthcare are important for youth to successfully transition to adult healthcare. The majority of CSHCN do not receive the needed support for transition. When compared to youth without special healthcare needs, CSHCN are less likely to complete high school, attend college, or be employed; thus, transition planning can help reduce these disparities and lead to greater success in adult life.

Title V lead/funding: The Children and Youth with Special Health Needs Section (CYSHNS) in the Children with Special Health Needs Branch (CSHNB) is the lead program for this priority measure. To ensure that transition planning benefits all youth, CYSHNS partners with the Maternal and Child Health Branch (MCHB) Adolescent Health Program to integrate transition planning into their Title V NPM 10 activities to promote adolescent wellness visits. The team meets monthly via Zoom.

Title V does not directly fund transition activities but does fund key CYSHNS staff including the Section Audiologist and Nutritionist. Both positions provide leadership for the Transition team. Title V also funds the CSHNB Chief, Research Statistician, and administrative staff who provide support to the Transition team.

Key Partners: Professional, state, and community organizations in Hawaii actively support and promote transition to adult life, including the American Academy of Pediatrics-Hawaii Chapter and Hilopa'a Family to Family Health Information Center (F2FHIC). F2FHIC trains medical providers, professionals, and families statewide in transition planning. A statewide network of youth agencies and programs collaborate on annual transition activities and events, including the Hawaii State Council on Developmental Disabilities and Hawaii State Department of Education (DOE).

Strategies: Hawaii has two strategies for transition:

- Incorporate transition planning into CYSHNS service coordination for enrolled youths and their families; and
- Provide education and public awareness on transition to adult healthcare and promote the incorporation of

transition services into organizational practices, in collaboration with state and community partners.

The first strategy is assessed by a scale to monitor progress on the integration of transition planning into the CYSHNS practices/protocol and serves as the NPM 12 strategy measure (ESM 1212).

Evidence: Hawaii's two transition strategies are based on the 2015 Title V needs assessment; Association of Maternal and Child Health Programs (AMCHP) NPM 12 Toolkit; MCH Evidence Center; MCH Workforce Development Center technical assistance; Got Transition website; and 2020 Federal Youth Transition Plan and national best practices and recommendations from Centers for Medicare and Medicaid Services (CMS) 2014 report titled, *Paving the Road to Good Health*. Progress on the strategies is described below. The Evidence Center indicates Hawaii's ESM to have 'moderate evidence' related to the use of the national core elements for transition.

Strategy 1: Incorporate transition planning into CYSHNS service coordination for CYSHNS-enrolled youth and their families

COVID Impacts: The pandemic had dramatic and significant impacts on CYSHNS operations, services, and client needs. The emergency orders in March 2020 resulted in most staff teleworking from home as only essential workers were permitted to commute to worksites. All in-person services continued through remote means (telephone or Zoom). All in-person CYSHNS neighbor island clinics were canceled, as interisland travel was suspended. Nutrition clinics for all islands continued through telehealth.

With most staff now accustomed to using Zoom, the pivot to telehealth was relatively easy. Some families, however, needed technical support and assistance adjusting to using telehealth. Some rural families had connectivity issues due to their remote location. Staff also witnessed the shift in clients' needs to necessities such as food, diapers, and rent/income assistance. Generally, the request for CYSHNS services during the pandemic decreased. Engaging families proved challenging, given changing priorities, so provision of transition services significantly declined. Family visits to their primary care physician (PCP) and medical specialists also decreased as in-person visits to healthcare providers were limited.

Core Elements: CYSHNS transition to adult healthcare efforts are guided by *Got Transition's Six Core Elements of Health Care Transition™*. The Core Elements are integrated into CYSHNS policies and procedures for youth and their parents/caregivers receiving CYSHN services for transition to adult healthcare. In 2020, a new Version 3.0 of the Core Elements was introduced to align with national guidance from professional medical organizations. However, the new version had little impact on CYSHNS protocols.

Core Element 1: Transition and Care Policy/Guide

The activities for this element focused on developing a CYSHNS transition policy and education for all staff on the transition policy and procedures. These activities were completed in 2020. The CYSHNS Transition Policy is posted on the CSHNB website: <http://health.hawaii.gov/cshcn/home/communitypage/>. All CYSHNS staff were educated on transition approach, policy, the Core Elements, and the roles of CYSHNS, youth/family, and pediatric/adult healthcare teams in the transition process. Staff were also educated on Title V's overall leadership role to improve MCH population health, including CSHN. Training content and program guidelines now also include the importance of cultural considerations. The information is included in new employee orientation.

Core Element 2: Tracking and Monitoring

The activities for this element establish a process to track progress on transitioning youth in the CSHNP client database. Update of the database is completed; however, only Oahu staff have direct access to the transition

information in the database. Efforts to extend access to statewide staff, including those on the neighbor islands, were delayed due to the pandemic.

Core Element 3: Transition Readiness

This core element activities ensure CYSHNS staff will meet with youth beginning at age 12-16 and parents/caregivers at least annually to assess transition readiness, progress, and to identify needs related to the youth's ability to manage his/her adult healthcare. Due to COVID-19, the implementation of transition readiness activities declined in FY 2020 since priorities for most youth and families shifted to more urgent daily needs, such as virus-related health/safety, educational/childcare supports, rental assistance/income stability, and accessing care for the most critical healthcare needs. Transition readiness activities were provided only for youth who needed to transition to adult healthcare because they were being discharged from the program.

CYSHNS staff continued to utilize transition tools to guide youth and parents/caregivers through the transition process. The materials were developed with youth/family input. These tools include:

- *Transition Readiness Assessment Checklist* (TRAC) assesses a youth's readiness level for transition to adult healthcare and allows the youth to select activities to help prepare for transition.
- *My Path to Adult Health Care* (PATH) is a visual flowchart of activities to guide youth in the transition to adult healthcare that promotes responsibility and self-advocacy in the areas of health habits, engaging healthcare providers, medications, health insurance, and adult healthcare.

Other providers are also using the materials to support transition planning including community hospitals and pediatricians, Kaiser Permanente Hawaii's pediatric practices, and Tripler Army Medical Center.

The *Follow Your Path to a Healthy Adulthood* handout is an educational flyer that provides a visual illustration of steps that can be taken to reach transition goals and can be distributed at events, such as health fairs.

Core Element 4: Transition Planning

The key activities for this core element assure transition planning is being conducted effectively by reviewing and updating the TRAC goals annually with youth/families to prepare youth to begin focusing on adult healthcare providers, health insurance, and personal responsibility.

As with Core Element 3, this activity was placed on hold during FY 2020 due to COVID-19 restrictions. Some staff have attempted to conduct assessment through mail or virtual visits but have reported reluctance from youth to participate in the activity. Staff will again attempt to complete this activity at a later time when youth are less stressed by COVID-19-related concerns.

Core Elements 5 and 6: Transition Transfer of Care and Transition Completion

The above activities culminate with youth and their parents/caregivers successfully transitioning to adult healthcare providers. Staff provide guidance, resources, and training to help youth apply for health insurance coverage as an adult, select adult healthcare providers, and manage their adult healthcare.

CYSHNS staff also assists with referrals to partnering adult service agencies through networks such as the state's *No Wrong Door* (NWD) program, which is an integrated person-centered system that supports individuals of all ages, disabilities, and payers. NWD's referral system provides a universal intake point for access to care.

From the start of the COVID-19 pandemic, transition to adult healthcare was addressed only if it was necessary for ongoing medical care. As noted earlier, the CYSHNS staff communicated with youth and families by mail or virtually

to make sure their medical needs were met.

ESM 12.1 Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult healthcare for Youth with Special Health Care Needs (YSHCN), related to *Got Transition's Six Core Elements of Health Care Transition™ 3.0*.

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Annual Objective			17	21	24	26	28	30	33	
Annual Indicator	12	13	18	22	24.5					

Strategy Measure Progress: ESM 12.1 measures the progress of CYSHNS work under Strategy 1. The rating scale has 11 strategy items adapted from *Got Transition's Six Core Elements of Health Care Transition™ 3.0*. CYSHNS staff scores each item from 0-3 for a maximum total score of 33. For FFY 2020, the ESM 12.1 score was 26.5 (80.3% completion), exceeding the annual target score of 24. The FFY 2020 indicator shows progress over the past year of 4 points, from the FFY 2019 indicator of 22.

Data Collection Form – FFY 2019

ESM 12.1: Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult healthcare for Youth with Special Health Care Needs (YSHCN), related to *Got Transition's Six Core Elements of Health Care Transition™ 3.0*. The scores below indicate the historical progress since 2016.

	0 Not Met	1 Partially met	2 Mostly met	3 Completely met
Transition and care policy/guide (core element #1)				
1. Develop a CYSHNS transition policy/statement, with input from youth, families, and providers, that describes the approach to transition, including consent/assent information.	0 2016			3 2017-20
2. Educate all staff about the approach to transition, policy/statement, Six Core Elements, and roles of CYSHNS, youth/family, and pediatric/adult healthcare team in the transition process, taking into account cultural preferences.	0 2016	1 2017	2 2018	3 2019-20
Transition tracking and monitoring (core element #2)				
3. Establish criteria and process for identifying and tracking transitioning youth in the CSHNP database.	0 2016	1 2017-18		3 2019-20
4. Utilize individual flow sheet or database to track youth's transition progress.		1 2016-18	2 2019/20	
Transition readiness (core element #3)				
5. At least annually assess transition readiness with youth and parent/caregiver using the TRAC, beginning at age 12, to identify needs related to the youth managing his/her healthcare (self-care).	0 2016	1-1.5 2017-20		
6. Jointly develop goals & prioritized actions with youth & parent/caregiver, & document in a plan of care in the TRAC.		1-1.5 2016-19	2 2020	
Transition planning (core element #4)				
7. At least annually update TRAC goals, in partnership with youth and families, including readiness assessment findings, goals, and prioritized actions.	0 2016	1 2017-20		
8. Prepare youth and parent/caregiver for adult approach to care before age 18, including legal changes in decision-making, privacy, and consent; self-advocacy; access to information; and insurance continuity.		1-1.5 2016-19	2 2020	
9. Develop and implement referral procedures to adult service agencies.		1 2017	2 2018-19	3 2020
Transition transfer of care (core element #5)				
10. Prepare youth and parent/caregiver for transferring to an adult healthcare provider and planning for health insurance coverage as an adult.		1-1.5 2017-19	2 2020	
Transition completion (core element #6)				
11. Contact youth and parent/caregiver, when CYSHNS services end, to confirm having an adult healthcare provider and health insurance coverage or provide further transition guidance.		1 2017	2 2018-20	
	2020 TOTAL = 24.5/33 (80.3% completion)			

Strategy 2: Provide education and public awareness on transition to adult healthcare for children/youth

with and without special healthcare needs and promote the incorporation of transition into planning and practices, in collaboration with state and community partners

This strategy focused on partnership activities to promote transition awareness among youth/families and workforce training on transition planning practices to youth organizations. The partnership strategy reflects local input from stakeholders and community/agency partners.

Educational/Awareness Events: CYSHNS, along with youth and family members, planned to continue multiple collaborations to conduct annual educational transition fairs and events through FY2020. However, with the advent of COVID-19 restrictions, most in-person transition outreach events to families/youth with special health needs were canceled or switched to virtual events. The in-person Oahu 2020 Transition Fair was changed to a statewide virtual event with participation from over 40 state and community agencies. One of the partners for the transition fairs is the state Department of Education (DOE), which worked towards having teachers, students, and families rapidly pivot to remote learning.

The largest event for youth and families of special need children is the annual Special Parent Information Network (SPIN) statewide conference, which is normally scheduled for April but was postponed to FY 2021. SPIN is a statewide parent-to-parent organization established to enhance the participation of parents of children with disabilities in the decision-making process for their child's education. SPIN continued to provide information, support, and referrals for parents of children and young adults with disabilities, as well as service professionals throughout 2020, via its website and newsletters. It is funded through a unique partnership between DOE and the Department of Health (DOH) Disability & Communication Access Board (DCAB). The conference is an important means to share transition information with the 400 family members and service providers who typically attend. Other family events that were canceled included the Hawaii Summer Special Olympics, Malama da Mind (Hawaii Island), Kauai's Legislative Forum, Kona's Marshallese Day, Healthy From Head to Toe, You Can't Have Inclusion Without Us, Parent Child Fair, and Keiki Steps.

Partnerships & Networking: CYSHNS connected to a broad network of government and community groups that help with systems coordination and advocacy for healthcare transition. Key planning partners included: MCHB Adolescent Health Program (responsible for the Title V NPM 10), DOE, SPIN, DCAB, DOH Developmental Disabilities Division, NWD, Hawaii State Council on Developmental Disabilities, Hilopa'a F2FHIC, Best Buddies Hawaii, Hawaii Maternal Child Health Leadership Education in Neurodevelopmental & Related Disabilities (MCH-LEND), Community Children's Council Office, Division of Vocational Rehabilitation, and other organizations. In 2020, the Kauai, West Hawaii, and Hilo Legislative Disability Forums also became network partners, providing another opportunity to share transition messages.

Organizational Practices: Transition planning has been incorporated into other CSHNB programs, including Hawaii Community Genetics Clinics, Early Language Working Group, and neighbor island cardiac, neurology, and nutrition clinics, as well as at MCHB-contracted adolescent residential facilities through their federal Personal Responsibility Education Program (PREP) grant.

The MCHB Adolescent Health Program has also integrated transition planning into the PREP program curriculum for at-risk and incarcerated youth living in residential facilities. The TRAC and PATH are used along with transition planning for employment and education. Because of COVID-19 stay-at-home orders, youth in the residential facilities were not allowed to leave the campus, nor were guests allowed to enter. This restriction provided an opportunity for staff to engage incarcerated youth in planning for their future, which includes adult healthcare.

CYSHNS formed a new partnership with the pediatric group at Kaiser Permanente Hawaii (KPH) to incorporate

transition to adult healthcare into their HMO system of care. KPH adopted *Six Core Elements of Health Care Transition™* into their pediatric department services and uses the TRAC and PATH handouts for patient planning with all youth in their healthcare system. This partnership will expand transition planning to a significant number of adolescents since KPH is the second-largest health insurer in Hawaii, insuring more than 250,000 members. In July 2020, training on 'supported decision-making' was held in collaboration with KPH, CYSHNS, State Council on Developmental Disabilities, and Hilopa'a F2FHIC.

Educational Materials: The CYSHNS Transition workgroup continued to meet monthly to work on outreach materials that can be understood across the literacy spectrum for populations with ESL or educational level limitations.

In partnership with MCHB Adolescent Health Program, TRAC, PATH, and Footsteps to Transition flyer materials were revised to include information on the importance of having a medical home and annual wellness visits. MCHB is disseminating these materials through their youth service programs and partners.

CYSHNS continued to work with the National MCH Workforce Development Center (WDC) to develop a transition informational campaign, following the completion of its 2019 cohort training with other states.

Current Year Highlights for FY 2021 through June 2021

Effects of COVID-19: CYSHNS services and activities continued through the COVID-19 pandemic with frequent modifications based on vaccination and disease rates, as well as the loosening of COVID restrictions. CYSHNS continued to telework from home through most of 2021 but are beginning to return to the office. All client services continued through remote means (i.e., phone, Zoom).

- Challenges and needs for families continue to focus on daily subsistence needs such as food, diapers, and rent/income assistance.
- Requests for CYSHNS services in 2021 have remained low, below 2019 levels.

Many preventive wellness visits were postponed during this COVID period. When wellness visits do occur, the focus has been on routine healthcare and maintaining immunization schedules; thus, transitioning to adult healthcare may not be a high priority for providers to address at this time.

All in-person events/clinics continue to be adversely affected by COVID:

- All in-person CYSHNS neighbor island clinics were canceled at the start of the pandemic. Nutrition clinics for all islands continued through telehealth.
- In October 2020, Maui restarted their Cardiac Clinics through telehealth.

Outreach Events: The annual SPIN statewide conference was rescheduled from April to October 2020, switching to a virtual format. Recordings of informational sessions are available online. One benefit of conducting a virtual SPIN conference is greater participation by neighbor island and rural families. CYSHNS participated in the SPIN advisory board for its annual statewide conference planning.

The virtual Footsteps to Transition Fair in Honolulu scheduled for October 2020 was postponed to Spring 2022.

New Partnerships: Surplus funds from reduced service provision was used to execute several contracts for assessment and messaging development. A contract with the University of Hawaii Center for Disabilities Studies will conduct ongoing assessment to document COVID impacts on CSHN and their families, using both primary and secondary data sources. Another contract was executed to partner with TeenLink Hawaii to develop messaging for youth, by youth on transition to adult healthcare for children with special health needs. A youth survey was developed

to collect information on youth healthcare knowledge, ability to access care/health information, and COVID impacts on routine care. The TeenLink survey will be disseminated for data collection in early Fall 2021.

Through the Community Children's Council, a new partnership has been formed with HMSA's Medicaid case managers to develop a transition toolkit. This toolkit will be shared with other Medicaid insurance plans.

Review of Action Plan for FFY 2020

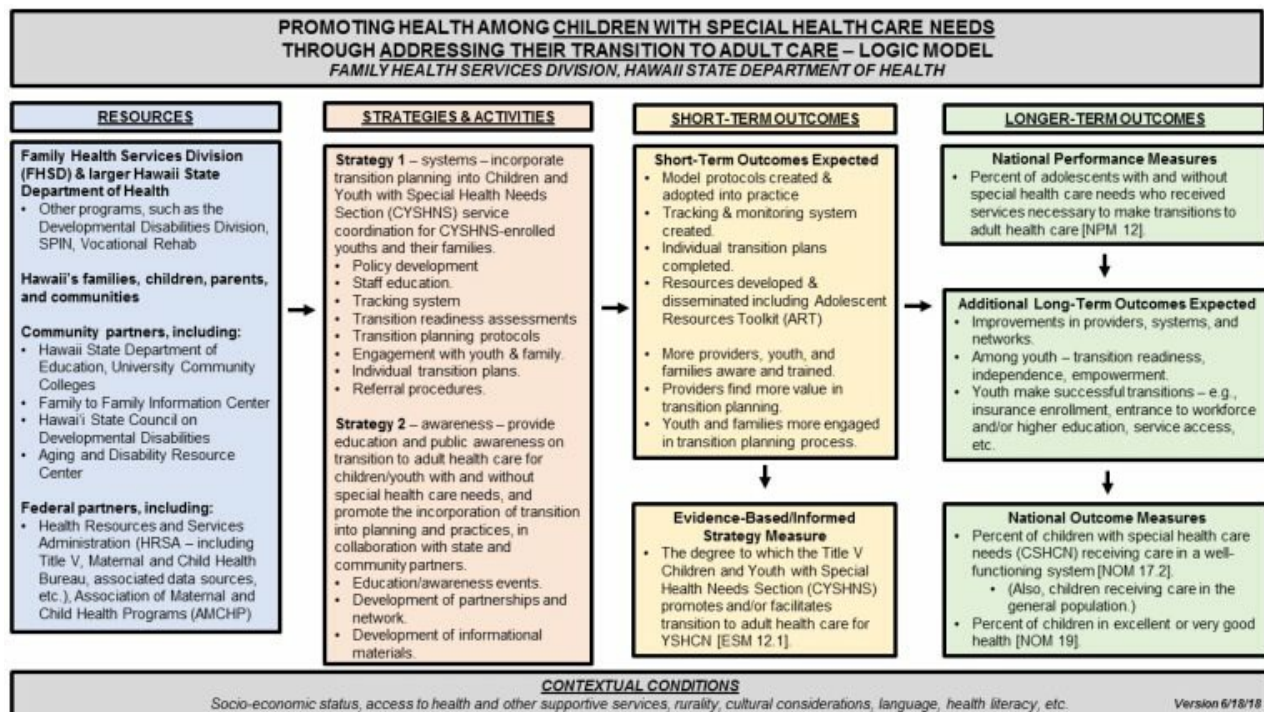
A logic model was developed for NPM 12 to review alignment among the strategies, activities, measures, and desired outcomes. By working on the two strategy areas, Hawaii focused on increasing the percentage of adolescents receiving transition services; however, the pandemic reduced the number of youths receiving transition services.

Strategy 1 focused on integrating the *Got Transition's Six Core Elements of Health Care Transition™ 3.0* into CYSHNS service protocols to ensure that youth enrolled in CYSHNS and their parents/caregivers, prepare for the transition to adult healthcare. This framework identifies the different planning components that need to be addressed. CYSHNS developed and established a program system of standardized policies and procedures, materials, and data collection methods that can be used by other agencies, healthcare providers, and community groups working with youth and transition.

Strategy 2 focused on public health education and awareness and supporting other youth servicing organizations to integrate transition planning into their service model through partnerships and networking.

In addition to assuring continual improvements in the ESM 12.1 and NPM 12, long-term outcomes included:

- Improvement in transition services offered by providers, systems, and networks;
- Among youth – greater transition readiness, independence, and empowerment; and
- Evidence of more youth making successful transitions to adult care.



Challenges encountered

The major challenge for 2020 and into 2021 has been overcoming barriers to care created by the pandemic. Many families delayed accessing healthcare during the pandemic for many reasons. The decrease in client-served numbers for direct services provided by CYSHNS and other Title V programs is a reflection of this problem.

CYSHN staff experienced some challenges with service provision during COVID restrictions:

- Staff have reported youth were reluctant to participate in transition assessment and planning.
- The traditional utilization of paper assessments and goal-setting forms did not interest the youth accustomed to electronic media.

CYSHNS is using this input to explore new ways of engaging and educating youth in transition planning. A future project is planned to conduct a needs assessment of youth to identify their preferred platforms for receiving information through social media, websites, phone applications, or written material. Transition assessment and educational material would then be developed and presented through these youth-endorsed platforms. Youth engagement is important in developing educational material for youth, by youth. A strong partnership with youth groups is needed to increase their involvement to benefit from their input.

Although CYSHNS staff made the shift to telehealth services, access to reliable internet connections and devices remained a challenge for some client populations and communities, especially in rural areas. Hawaii is creating another new state priority to help expand access to telehealth hubs in underserved/rural communities, which may also help increase access to CYSHN services.

The COVID pandemic also amplified the reality of health disparities in the state. CYSHNS is creating a health equity strategy to focus on assessment and is expanding engagement with community groups to help address these disparities.

CYSHNS will also complete work to expand the client transition tracking features in the program database to all staff statewide. Access for neighbor island staff is scheduled to begin in August 2021.

For Strategy 2, COVID provided enormous challenges to traditional outreach in-person efforts where youth/parents could readily access and learn about available services and products in a comfortable client-centered environment. Many of these events were done in partnership with the state public school system, which shut down and offered limited services to special education students. Several of the larger events were rescheduled and conducted virtually.

Although many strong partnerships have been established over the last five years around transition planning, a major challenge remains identifying and establishing partnerships specifically with adult healthcare providers/agencies to access and also encourage transition of youth to adult healthcare, especially among healthcare specialists. More partnerships with healthcare providers/organizations like the KPH collaboration are needed including health insurers, Medicaid, and physician networks.

To expand collaboration across sectors, the challenge has been highlighting the importance of transition planning for all youths, not just those with special healthcare needs. CYSHNS will continue to identify community partners and work with them in promoting transition planning in their populations. Potential partners are TeenLink Hawaii, Hawaii Afterschool Alliance, HMSA MedQUEST, AlohaCare, Leadership in Disabilities and Achievements of Hawaii (LDAH), and the Center for Disabilities Studies.

Another challenge has been developing methods to measure the effectiveness of health education and awareness

activities. As part of the new database revision, fields will be added to capture community events, education, and community outreach for transition. CYSHNS will research tools to quantify outcomes with assistance from the national *Got Transition* program, MCH Evidence Center, and MCH WDC. The recent release of *Got Transition 3.0* in 2020 is filled with helpful tools and implementation guides. CYSHN staff will review this new resource to update and revise their transition activities.

Technical assistance has been sought to design more effective messaging and outreach methods to reach youth, including the use of social media and technology. Guidance from MCH WDC helped address this need by providing staff with knowledge and tools around health communication strategies and project management. The partnership with the MCHB Adolescent Health program also helped to address this concern by sharing resources and connecting with their network of youth service partners.

Overall impact

Over the past five years, CYSHNS was successful in developing a system to help youth transition to adulthood. CYSHNS fully integrated transition planning into its standard program services. The transition workbook, program brochure, TRAC, PATH, and Footsteps to Transition flyer were developed by CYSHNS with continuous feedback from youth, families, staff, and partners. These tools have been valuable to educate, develop, and track life goals as youth transition to adulthood.

These resources are also now widely used by system partners including DOE, pediatricians, health centers, and the Hawaii military healthcare system as part of their transition planning services. The recent collaboration that was established with Kaiser pediatric services to integrate transition into their system practices demonstrates the utility and ability to replicate CYSHNS protocols and practices. CYSHNS is exploring the development of a formal transition toolkit for use by other healthcare/youth-serving organizations.

Another major success has been the development of strong partnerships among service providers and agencies to help Hawaii youth transition to adulthood, as evidenced by the number of youth/family community events aimed at promoting transition, including the DOE hosted *Footsteps to Transition* fairs. Events are held annually across all counties and have expanded to include a comprehensive array of services and educational providers. In partnership with DOE, the Transition Fairs have created other outreach and educational events for public and adult healthcare providers, as well as workforce training events for providers. The planning for many of these events and trainings involve a high level of family and youth participation and input.

The CYSHNS staff benefited from FHSD investments in telehealth equipment, software and, training and were already regular Zoom users when the pandemic shutdowns occurred. CYSHCN staff made the switch to telework and telehealth services with relative ease and were able to help families with the changes. The Genetics program developed family-friendly educational videos to help clients transition to using telehealth.

Children with Special Health Care Needs - Application Year

NPM 12 – Percent of adolescents with and without special healthcare needs, ages 12 through 17, who received services necessary to make transitions to adult healthcare

For the Children with Special Health Care Needs (CSHCN) population domain, Hawaii selected NPM 12 Transition to Adult Health Care as a continuing priority, based on the results of the 2020 5-year needs assessment. Over the previous five years, the data did not show a significant improvement in transition services for YSHCN, rather just for adolescents in general. By July 2025, the state seeks to increase the percent of youth with (and without) special healthcare needs who received transition services to 27%. Plans to address this objective and NPM are discussed below.

Strategy 1: Incorporate transition planning into CYSHNS service coordination for CYSHNS-enrolled youths and their families

Transition and care policy/guide

- Although this element has been met, ongoing education of CYSHNS staff regarding policy and procedures for transition will continue through monthly transition meetings and new CYSHNS employee orientation.

Transition tracking and monitoring

- Staff to continue to administer the TRAC form to track and monitor the progress of transition activities.
- Provide access to the new system to all CYSHNS staff, including those on the neighbor islands. When completed generate reports to assess/evaluate program progress on transition.
- Train all professional CYSHNS staff on the use of the new database.
- Complete the addition of a flow sheet in the database to track when youth receive each core element.

Transition readiness

- Continue to revise the program brochure, PATH, TRAC, and Beach flyer in response to the changing focus and needs of youth and families. Include COVID-19 information and resources.
- Continue to obtain feedback from youth and parents/caregivers on revisions to transition planning tools.

Transition planning

- Needs assessment will be conducted to evaluate the effectiveness of transition tools.
- Develop a system for receiving referrals into the CYSHNS program, for youth and families seeking assistance with transitioning to adult healthcare.
- Continue participation in the NWD network of agencies.
- Continue to partner with youth agencies and healthcare providers in distributing information on transition to adult healthcare.

Transition transfer of care

- Continue work toward helping CYSHNS-enrolled youth and parents/caregivers prepare for adult healthcare.

Transition completion

- Research ways of ensuring completion of transition and ways of documenting and quantifying completion.
- Develop a scorecard or survey for youth and adult healthcare providers to verify transition completion.

Strategy 2: Provide education and public awareness on the transition to adult healthcare for children/youth with and without special healthcare needs and promote the incorporation of transition into

planning and practices, in collaboration with state and community partners

CYSHNS will continue to work with agency and community partners to modify and adapt outreach events and methods of youth/family engagement to deliver transition information and services during the COVID-19 pandemic. Even as COVID-19 restrictions are being eased, in-person group meetings may continue to be restricted unless essential and only under conditions safe for both families and providers. Virtual means of conducting focus groups or group events will continue to be considered. New partnerships with the TeenLink Hawaii youth network and Leadership in Disabilities and Achievements of Hawaii (LDAH) will encourage and support youth engagement in developing transition policy and messaging.

CYSHNS will continue to engage youth to assess and evaluate transition messaging through the ongoing partnership with the TeenLink youth network. A new partnership with HMSA QUEST health insurance plan will develop age range-specific transition tool kits, which will be shared with all Medicaid health insurance plans. HMSA is the Blue Cross provider in Hawaii and is the largest health insurance plan in the state, insuring over 500,000 individuals.

CYSHNS will continue its partnership with Kaiser Permanente Hawaii to integrate transition to adult healthcare planning services and collaborate on provider training.

Strategy 3: Develop and expand efforts to address health disparities in transition services for youth

Needs assessment work with the University of Hawaii Center for Disabilities Studies will continue to document the impact on COVID for CYSHCN and their families. Data collection is planned to reach out broadly to youth/families to identify key disparities. The findings will be used to inform Title V priorities and strategies. Specifically, transition services, messaging, and outreach may all be revised given the feedback collected.

CYSHNS will continue to seek and establish new partnerships to address disparities including Medicaid and Native Hawaiian/Pacific Islander youth organizations.

Title V CSHCN Programs

Children with Special Health Needs Branch (CSHNB) is working to assure that all children and youth with special health care needs (CSHCN) will reach optimal health, growth, and development. Programs include:

Birth Defects: Provides population-based surveillance and education for birth defects in Hawaii and monitors major structural and genetic birth defects that adversely affect health and development.

Childhood Lead Poisoning Prevention: Reduces children's exposure to lead by strengthening blood lead testing and surveillance, identifying, and linking lead-exposed children to services and improving population-based interventions. The program is funded by the Centers for Disease Control and Prevention (CDC).

Children and Youth with Special Health Needs: Assists with service coordination, social work, nutrition, and other services for children with special healthcare needs, ages 0-21 years, with chronic medical conditions. It serves children who have or may have long-term or chronic health conditions that require specialized medical care and their families.

Early Childhood: Focuses on systems-building to promote a comprehensive network of services and programs that helps children with special health needs and children who are at risk for chronic physical, developmental, behavioral, or emotional conditions reach their optimal developmental health.

Early Intervention Section: Provides early intervention services for eligible children, ages 0-3 years, with developmental delay or at biological risk as mandated by Part C of the Individuals with Disabilities Education Act. Services include: care coordination; family training, counseling, and home visiting; occupational therapy; physical therapy; psychology; social work; special instruction; and speech therapy. Parents/caregivers are coached on how to support the child's development within the child's daily routines and activities.

Genetics Services: Provides information and education about topics in genetics statewide and services to neighbor island families.

Hi'ilei Developmental Screening: A free resource for parents of children from birth to 5 years old. The program provides developmental screening via a mail or online screen; activities to help a child develop; referrals for developmental concerns; and information about state/community resources.

Newborn Hearing Screening: Provides newborn hearing screening for babies as required by Hawaii state law to identify hearing loss early so that children can receive timely early intervention services.

Newborn Metabolic Screening: Provides newborn blood spot testing for babies as required by Hawaii state law. The tests help detect rare disorders that can cause serious health, developmental problems, and even death, if not treated early.

Cross-Cutting/Systems Building

State Performance Measures

SPM 3 - The number of pediatric and/or behavioral health providers receiving training and support services on pediatric mental health care in underserved communities/counties statewide.

Measure Status:		Active
State Provided Data		
	2020	
Annual Objective		
Annual Indicator	0	
Numerator		
Denominator		
Data Source	Hawaii Pediatric Mental Health Care Access grant	
Data Source Year	2020	
Provisional or Final ?	Final	

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	20.0	40.0	60.0	80.0	100.0

SPM 4 - Number of new telehealth access points established with health and digital navigators in public libraries located in underserved communities statewide

Measure Status:		Active
State Provided Data		
	2020	
Annual Objective		
Annual Indicator	0	
Numerator		
Denominator		
Data Source	Hawaii Title V Genetics Program	
Data Source Year	2020	
Provisional or Final ?	Final	

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	9.0	15.0	15.0	15.0	15.0

State Action Plan Table

State Action Plan Table (Hawaii) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Address health equity and disparities by expanding pediatric mental health care access in rural and under-served communities

SPM

SPM 3 - The number of pediatric and/or behavioral health providers receiving training and support services on pediatric mental health care in underserved communities/counties statewide.

Objectives

By July 2025, provide training and support services on pediatric mental health care to 80 pediatric and/or mental health care providers in underserved communities statewide.

Strategies

Refine, develop and implement pediatric mental health care access model

Promote workforce development and training on pediatric mental health care

Support services and linkages in communities

State Action Plan Table (Hawaii) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Address health and digital equity by expanding access to telehealth information and services in state public libraries located in underserved communities.

SPM

SPM 4 - Number of new telehealth access points established with health and digital navigators in public libraries located in underserved communities statewide

Objectives

By July 2023, establish fifteen new telehealth access points with health and digital navigators in public libraries located in underserved communities statewide.

Strategies

Telehealth Library Access Project infrastructure development

Workforce development

Service provision

2016-2020: State Performance Measures

2016-2020: SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers.

Measure Status:				Active	
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			11	13	14
Annual Indicator					
Numerator	8	11	28	42	72
Denominator	72	72	72	72	72
Data Source	Telehealth work group, Family Health Services Divi	The preliminary 5-year plan objectives were develo	Telehealth work group, FHSD	Telehealth work group, FHSD	Telehealth work group, FHSD
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

SPM 3 - The number of pediatric and/or behavioral health providers receiving training and support services on pediatric mental health care in underserved communities/counties statewide.

Introduction: Children's Mental Health

For the Cross-Cutting domain, Hawaii has added a new state priority to expand children's mental health services in response to concerns that emerged due to the COVID pandemic. In the 2020 Needs Assessment, mental health was identified as a concern for children and youth; however, Hawaii decided not to select this issue as a priority due to a lack of program capacity and in recognition of the DOH Child and Adolescent Mental Health Division (CAMHD) that is the lead for this program area.

COVID highlighted a growing concern over mental well-being due to pandemic-related health problems, social isolation, and economic hardships that generated widespread stress, anxiety, depression, and other mental health concerns. With the closure of schools and youth activities, and reduced access to outdoor spaces, family stress increased substantially.

Data: Mental health issues, particularly for youth suicide depression, was identified as a priority need in the 2020 Title V needs assessment completed before the pandemic. This was reflected in the health data as well as family and stakeholder input.

Two of the leading causes of adolescent mortality in Hawaii are unintentional injuries, such as motor vehicle-related injuries and suicide. Unfortunately, Hawaii has a comparatively high rate of adolescent suicidal ideation, and this rate has steadily increased over the years. The suicide death rate for youth ages 15-24 in Hawaii is 19.3, which is high compared to the U.S average of 14.4 for this age range.

Emergency Department (ED) Data: Analysis of Hawaii Emergency Department (ED) admissions data conducted by the DOH Injury Prevention program show that prior to COVID, there was an increase in the annual number of emergency room visits related to teen suicide ideation, doubling from 284 in 2016 to 525 in 2019. Although there was a decrease to 460 visits in 2020, this may reflect the general overall decrease in ED visits during COVID. As a proportion of ED visits, the percentage of youth suicide related ED visits increased from 2019 to 2020.

Anecdotally, both Hawaii ED doctors and hospital administrators from two of Hawaii's major hospitals reported in 2020 that they saw more adolescents being held in ED beds for longer periods, too unstable for discharge, waiting for space at Oahu's two acute care facilities that serve youth.

In the rural neighbor island counties, ED data confirms youth have a higher reported rate of suicide-related visits. But this may reflect lower access to mental health services in rural areas and/or greater use of emergency room services by neighbor island residents. On Oahu, there are more options for behavioral health services, and residents may elect to go to a private physician or behavioral health provider for support.

The need to support youth after ED visits for any mental health illness is crucial. According to Hawaii Medicaid quality assurance 2019 data, only 34% of youth ages 6-17 who were admitted to an ED for mental illness received follow-up care within seven days following ED discharge.

Provider Shortage: COVID has also exacerbated the provider shortage. Of the 989 medical provider offices surveyed in 2020 (all disciplines), 44% said that the pandemic has disrupted their practice in the form of temporary and permanent clinic closures, early retirement, increased telehealth practice, altered operating hours and locations,

and reduced patient volume. The loss of providers and increase in provider shortage estimates are seen in every county.

While there are currently 153.4 FTE active psychiatrists in the state, there is an estimated shortage of 17.9 FTE providers and not all psychiatrists specialize in serving children and adolescents. Shortages of psychiatrists are especially critical in rural communities on Oahu and in the counties of Hawaii, Maui, and Kauai.

According to the Centers for Disease Control and Prevention (CDC), a 2015 report shows that while Honolulu County (the island of Oahu) may have the highest number of psychiatrists, it still has a relatively low rate of providers in comparison to the estimated 306,000 children aged 0-17 who may need to access their services.

In rural areas of Oahu as well as neighbor islands, where the provider shortages are higher, residents also confront geographic and transportation barriers to accessing behavioral healthcare. Most tertiary healthcare facilities, specialty and subspecialty services, and healthcare providers are located in urban Oahu. Consequently, residents on Hawaii Island, Kauai, Maui, Molokai, and Lanai (collectively the “neighbor islands”) are usually required to travel to Oahu for specialty care. With the onset of COVID, there have been limited flights to and from certain islands, such as Molokai and Lanai. Airfare costs can be volatile as prices are based on fluctuating fuel costs, which creates a financial barrier for neighbor island residents; roundtrip airfare can range from \$130 to \$300. Also problematic now is the shortage of rental cars on all islands for transportation, adding to the costs of accessing care.

Access to emergency care on neighbor islands may also require the use of helicopters or fixed-wing aircrafts. Access to healthcare on the rural neighbor islands is also challenging because public transportation is limited, so residents must rely on cars to travel to the major population centers for healthcare. In many areas of the neighbor islands, the terrain is mountainous and roadways are limited to a single lane. A traffic accident, fallen tree, or treacherous driving conditions caused by weather can result in lengthy delays in accessing healthcare.

Funding Opportunity: With the 2021 announcement of the HRSA Pediatric Mental Health Care Access (PMHCA) grant, FHSD had an opportunity to build program capacity around mental health. With the PMHCA grant, Hawaii will establish a statewide system of behavioral health teleconsultation and care coordination for children, especially those in underserved areas and rural communities where there are severe shortages of behavioral health providers as well as other barriers to care.

This project will provide pediatric healthcare providers access to a pediatric mental health care team that will support their work with children and youth. Trainings on pediatric mental health care and on the pediatric mental health team model will be provided in the communities so that there will be statewide access to the pediatric mental health care team(s). Overall, the goal is to promote integration of primary care and behavioral health in order to better services children, youth, and their families in their communities

Evidence: HRSA recently provided additional funding to support all Title V agencies to implement the Pediatric Mental Health Care Access Program, which promotes behavioral health integration into pediatric primary care using telehealth delivery. State or regional networks of pediatric mental health teams provide teleconsultation, training, technical assistance, and care coordination so that pediatric primary care providers can better diagnose, treat, and/or refer children and youth with behavioral health conditions. The overarching goal of the program is to use telehealth modalities to provide timely detection, assessment, treatment, and referral of children and adolescent with behavioral health conditions, using evidence-based practices and methods such as web-based education and training sessions. The MCH Evidence Center has provided ample evidence to show that telehealth services can improve access to healthcare for underserved MCH populations.

Title V lead/funding: The PMHCA grant is administered by FHSD and will allow FHSD to fund two staff positions to help maintain and build the program. Although no Title V funds will be used to support the program, Title V-funded staff will assist with data, contractual, and media support.

Key Partners: This new project is a unique collaboration between the Department of Health, John A. Burns School of Medicine (JABSOM), Project ECHO Hawaii, Hawaii Primary Care Association, and University of Hawaii Pacific Basin Telehealth Resource Center. This multi-agency collaboration will ensure that pediatric providers can access needed mental health consultation services in underserved communities statewide. The project will also coordinate with DOH efforts to establish a statewide mental health services/referral system led by the DOH Child and Adult Mental Health programs.

Objective: By July 2025, provide training and support services on pediatric mental health care to 80 pediatric and/or mental health care providers in underserved communities statewide.

Strategies: The strategies to implement the project will focus on three key areas:

- Refine, develop and implement a pediatric mental health care access model
- Promote Workforce development and training on pediatric mental health care
- Support services and linkages in underserved communities

Activities for implementation for each of the strategic areas is described in the application plans for this new state mental health priority.

The funding for the new project is anticipated to be awarded by September 29, 2021. FHSD staff will prepare administrative requests needed to secure approvals to establish accounts, budgets, new position descriptions, as well as needed procurement with grant partner contracts.

Current Activities FY 2021 through June 2021

Although mental health was not selected as a state priority, FHSD strategically utilized partnerships to support work in this area.

Partnerships within DOH: FHSD and CAMHD continued discussions to help clarify the distinct roles for both programs regarding child mental health. CAMHD has traditionally been identified as the lead for children and youth's mental health as they service the 3- to -21-years-of-age population with identified mental health concerns. FHSD's role has traditionally been focused more on prevention and early identification and partnering with the primary care workforce through the Office of Primary Care and Rural Health.

CAMHD's role has been focused on building the referral and treatment system for high-end treatment services for children and youth, and it works primarily with the mental health and behavioral health system providers. Opportunities to build collaboration between the two divisions focused on workforce training efforts and legislation to promote trauma informed-care practices.

Infant/Early Child Mental Health: The development of Hawaii's Integrated Infant and Early Childhood Behavioral Health Plan was completed through a partnership with FHSD and:

- Hawaii Community Foundation,
- Early Childhood Action Strategy collaborative,
- Association for Infant Mental Health Hawaii (AIMH-HI), and
- Executive Office on Early Learning.

The plan addresses four areas: Systems and Policy; Marketing, Outreach, and Community Education; Workforce Development; and Programs and Services. It was commissioned at the request of the state Early Learning Board (ELB), a public-private governing board tasked with formulating statewide policy relating to early learning. ELB recognized that children's social emotional/behavioral health issues may be adversely affected by the COVID pandemic restrictions. FHSD provided resources and leadership for the plan and continues to support implementation. Partnerships established during the plan development helped support the PMHCA grant efforts. Also, elements of the infant/early childhood behavioral health plan were integrated and will coordinate with strategies in the PMHCA grant.

Data: SSDI grant funding was used to conduct a preliminary review of data regarding child/youth mental health and disparities. The information was used for the HRSA PMHCA grant and is being used to develop a data publication. With limited FHSD epidemiologist support, a contractor is being secured to complete the project.

SPM 4 - Establish new telehealth access points with health and digital navigators in public libraries located in underserved communities statewide.

Introduction: Telehealth Access

For the Cross-Cutting domain, Hawaii added this new state priority to expand telehealth services to underserved communities in response to health and digital equity issues that emerged because of the COVID pandemic.

As reported in the final report of the State Performance Measure 1 (Increase the use of telehealth across Title V activities to improve access to services and education for families and providers) from 2015, 100% of the Hawaii Title V programs adopted the use of telehealth prior to and during the pandemic. However, the pandemic highlighted the health and digital inequity experienced by many underserved families. Some families do not have the digital literacy to access online information and services or do not have devices and/or adequate internet or cellular service, even if they know how to use the internet. Before COVID-19, FHSD setup telehealth access at all of the neighbor island District Health Offices to provide some access for families. But during the statewide COVID emergency, these sites were closed to all outside visitors.

This new project will provide individuals and families with the ability to access health and digital navigators, computers with internet, and telehealth rooms in public libraries located in underserved communities statewide.

Evidence: A review of the MCH Evidence Center shows evidence is fairly strong for use of telehealth to increase access to underserved populations for women's preventative health services; pregnancy and post-partum health messaging; adolescent health; parenting support for infant and toddler health; raising awareness about child mental health and health insurance access; reaching underserved children via teledentistry; and supporting child/adolescent mental health via teleconsultation.

Title V lead/funding: Within FHSD, the Genetics Program continues to serve as the telehealth lead for the Title V agency. After successfully integrating the use telehealth technology throughout the Title V agency, this project focuses on addressing telehealth access issues to reach underserved communities in the state. Funding for this project is from a Centers for Disease Control and Prevention grant: *National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities* awarded June 2021.

Key Partners: This new project is a unique collaboration of the Hawaii State Department of Health (DOH), State Public Library System, and the University of Hawaii (UH) Pacific Basin Telehealth Resource Center and University John A. Burns School of Medicine. The project will provide individuals and families with the ability to access health and digital navigators, computers with internet, and telehealth rooms in libraries located in underserved communities statewide.

Objective: By July 2023, establish 15 new telehealth access points with health and digital navigators in public libraries located in underserved communities statewide.

Strategies: The strategies to implement the project focus on three key areas:

- Telehealth Library Access Project infrastructure development
- Workforce development
- Service Provision

Activities for implementation for each of the strategic areas is described in the application plans for this new state priority.

The funding for the new project was awarded to DOH on June 1, 2021. By September 30, 2021, FHSD staff will complete the paperwork to set up the project; get approvals from the governor and director of health as needed; create position descriptions; procure equipment; and set up the collaboration with the state public library, UH, community-based organizations, and families in the 15 communities near each library in the project.

SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services, education, and training for families and providers (count).

Introduction: Telehealth

Expanded use of telehealth technology was identified as a priority in the 2015 Title V five-year needs assessment. The objective stated that by July 2020, 100% of Hawaii Title V programs would use telehealth to provide services, education, and/or training.

Data: This SPM goal was met at 100%. The COVID-19 pandemic compelled all Title V programs throughout 2020 and into 2021 to fully utilize the telehealth investments in training, software, and equipment to facilitate telework, virtual client services, and expand networking with agency and community partners through video conferencing. This priority will be retired in 2020 since it has been fully achieved. No further objectives are set.

Title V Lead/Funding: Within the Family Health Services Division (FHSD), there is ongoing support for efforts to implement or increase telehealth activities for genetics, newborn screening, early intervention, and home visiting program activities. These efforts are led by the Genomics Section, which is the grantee for the HRSA Western States Regional Genetics Network (WSRGN). WSRGN is a leader in the use of telegenetics and has many resources that FHSD can leverage for the Title V telehealth initiatives. Although Title V does not fund telehealth activities directly, key management and support staff funded by Title V help facilitate the telehealth expansion activities described in this narrative.

Key Partners/Policies: Prior to the pandemic, Hawaii's governor and legislature identified telehealth as a top priority for the state. Hawaii has progressive telehealth statutes and congressional representatives had secured major funding to expand telehealth resources for Hawaii and the Pacific. Thus, telehealth continued to increase including programs within the Hawaii State Department of Health (DOH), hospitals statewide, community organizations, and the University of Hawaii. These efforts are supported by the HRSA-funded Pacific Basin Telehealth Resource Center (PBTRC) that works to help stakeholders collaborate on telehealth activities.

Strategies: There are four strategies for this measure: Infrastructure development, workforce development, service provision, and education/training. The strategies were developed by the FHSD staff and led by the CSHNB Genomics Section Supervisor, who serves as the FHSD lead for the telehealth priority.

Report FY 2020 through June 2021

Here are some highlights of current telehealth activities for FY 2021, including the impacts and changes due to the COVID-19 pandemic in Hawaii.

Since 2015, FHSD invested resources for telehealth in Title V programs. The planning, infrastructure development, and training employed to build telehealth capacity prepared the Title V programs to quickly move to virtual activities during the COVID-19 public health emergency and into the present.

Prior to the pandemic, most FHSD programs were using videoconferencing largely for meetings and trainings. The use of Zoom videoconferencing was the norm throughout division program operations and activities. However, the pandemic compelled FHSD programs to exclusively use videoconferencing for the majority of the work with so many employees mandated to telework from home.

The trend supporting provider and family adoption of telehealth continued and has since expanded to include collaboration with federal and state government agencies and community partners. The Genetics Program continued to maintain and expand telehealth resources and technical assistance (TA) that quickly increased in the first few months of the pandemic and initial lock down in Hawaii. The resources and activities included:

- Updating and maintaining a five-minute animated video, *Best Practices for Providers*, demonstrating best online practices for healthcare providers that's usually presented in a more extensive training course.
- Updating and maintaining the English and Spanish versions of an eight-minute video, *What to Expect from a Telehealth Visit*, for families and patients to explain telehealth and also what to do to receive telehealth services in one's home. Versions were also created with increased volume and no background music at the request of families who have hearing impaired family members.
- Working with PBTRC to update and maintain telehealth resources, including quick start guides, billing policies, information for patients, checklists, and locations/providers on the PBTRC website.
- Updating and maintaining the videos and resources used by the HRSA Office for the Advancement Telehealth and the new Health and Human Services telehealth website. The resources Hawaii developed were adopted nationally, with local contact information switched to the National Consortium for Telehealth Resource Centers for national dissemination.
- From April 1, 2020 to June 30, 2021:
 - Best Practices Video views: 14,074
 - What to Expect Video views (English): 12,025
 - What to Expect Video views (Spanish): 112
 - What to Expect Video views (Vietnamese): 33
 - What to Expect Video views (Chinese Mandarin): 1,699
 - What to Expect Video views (Samoan): 20

- The Genomics Program collaborated with PBTRC and continued telehealth TA webinars weekly for all providers, including the Title V programs, from June to August 2020. The webinars shifted to a monthly schedule from August to December 2020 and then were offered as needed starting in January 2022.
- The Genomics Program received additional CARES Act funding through the Association of Maternal and Child Health Programs (AMCHP) to increase telehealth resources for families in the Western States Region (Washington, Idaho, California, and Hawaii). This funding allowed the program to:
 - Transconvert (translation and conversion of the video for language and visual elements to meet cultural needs) the *What to Expect from a Telehealth Visit* video into Vietnamese, Samoan, Chinese (Mandarin), Tagalog, and Korean. The Chinese (Cantonese), Ilocano, Korean, and Russian versions are currently under development.
 - Develop and maintain a seven-module online telehealth training for family advocates, Title V staff, and other community program staff that work with families. The training provides a foundation to help advocates and staff navigate families to telehealth services and resources. The training is free, and a certificate of completion is provided.
 - Developed a dedicated section of the Western States Regional Genetics Network (WSRGN) website (<https://www.westernstatesgenetics.org/family-telehealth-resource-project/>) to help advocates, staff working with families, and families to centralize different types of resources to help families.

Factors Contributing to Success

The major factors contributing to the success in expanding telehealth throughout Title V programs continue to be support from the governor, state legislature, DOH administration, FHSD/program leadership, program staff, and other public sector agencies such as the University of Hawaii and HRSA-funded PBTRC. The legislature approved funding since 2017 for a State Telehealth Coordinator position within DOH and development and maintenance of a State Telehealth Plan. DOH also consolidated the individual Zoom videoconferencing licenses into one HIPAA-compliant corporate license to allow more efficient expansion for telehealth for all public health programs.

Having telegenetics activities developed and implemented as part of the HRSA-funded WSRGN, which is administered within the Hawaii Title V agency, really helped harmonize expansion of telehealth activities in FHSD programs. The long-standing partnership with the HRSA-funded PBTRC also greatly supported telehealth activities, especially with the advent of the COVID pandemic.

As a state, we have developed a Statewide Telehealth Hui and Statewide Broadband Hui (“*hui*” is the Hawaiian word for group). Both of these groups are working towards developing policies, programs, and funding to support digital and health equity as well as access for all families in Hawaii. In the 2021 legislature, the creation of a Broadband Coordinator was approved. This coordinator is tasked to sustain development efforts for digital equity in Hawaii.

Challenges

Hawaii was fortunate to quickly adopt the use of telehealth for Title V programs during the pandemic. However, there are still issues with ensuring adequate internet or cellular connections especially for staff, clients, and families in rural areas of the state.

A major disparity continues for families who are not able to receive telehealth services in their homes due to a lack of devices and/or adequate internet or cellular service. Before COVID-19, FHSD setup telehealth access at the neighbor island District Health Offices to address this concern. However, during the COVID lockdown, these sites were closed to outside visitors. FHSD programs continue to work with state programs, community-based organizations, healthcare providers, and internet/cellular carriers to expand the availability of devices and internet/cellular services.

Cross-Cutting/Systems Building - Application Year

SPM 3 - The number of pediatric and/or behavioral health providers receiving training and support services on pediatric mental health care in underserved communities/counties statewide.

For the Cross-cutting domain, Hawaii has selected this new state priority and performance measure, which emerged from Title V assessment efforts in 2020. By September 2025, FHSD's Pediatric Mental Health Care Access grant will establish and provide training to 80 pediatric and behavioral health providers in underserved communities statewide. Specific plans to address this objective and SPM are located within the Hawaii Department of Health, Pediatric Mental Health Care Access grant which is anticipated to be awarded September 2021. The 3 strategies and activities are presented below.

Strategy 1: Refine, develop, and implement pediatric mental health care access model

- Hire Project Coordinator and Assistant to coordinate the project activities within FHSD.
- Convene Advisory Group to meet quarterly to help advise on implementation of project.
- Execute Contracts for services.
- Review existing PMHCA models and develop a state model for implementation.

Strategy 2: Promote Workforce development and training on pediatric mental health care

- Meet with mental health consultant contractors to develop training curriculum.
- Develop and pilot curriculum and training to five providers with evaluation parameters.
- Refine training and curriculum as needed, and deliver to 20 community providers.
- Develop and implement evaluation of training with evaluation analysis.
- Sustain and archive training for on-going professional development use in community.

Strategy 3: Support services and linkages in the community

- Coordinator and Assistant Coordinator will help individuals and families access information about mental health and telehealth services available for children and youth.
- Coordinator and Assistant Coordinator will work with families who receive behavioral health services to help evaluate their experience.
- Focus groups and meetings within underserved target communities will be conducted, to help determine best services model development for the community.

SPM 4 - Establish 15 new telehealth access points with health and digital navigators in public libraries located in underserved communities statewide.

For the Cross-Cutting domain, Hawaii selected a new state priority and performance measure, which emerged from assessment efforts in 2020. By July 2023, establish 15 new telehealth access points with health and digital navigators in public libraries that are located in underserved communities statewide. Plans to address this objective and SPM are from DOH/CDC grant: *National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities* awarded in June 2021. The three strategies and activities are presented below.

Strategy 1: Telehealth Library Access Project infrastructure development

- Librarian Project Coordinator will be hired to coordinate the project activities.
- The project coordinators on each island will be hired.
- Individuals from each community will be hired as health/digital navigators for each library.
- Telehealth equipment will be procured for each library.
- The private room in each library will be set up for telehealth.
- Contracts for services will be executed.

Strategy 2: Workforce development

- The training for the telehealth project staff will be set.
- Any new training resources will be developed.
- Training will be provided to staff.
- Development and implement evaluation of activities.

Strategy 3: Service Provision

- Health/digital navigators will help individuals and families locate information about telehealth and make telehealth appointments.
- Health/digital navigators will help individuals and families complete the scheduled telehealth appointment.
- Health/digital navigators will have individuals and families who receive services do an evaluation of their experience.

SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services, education, and training for families and providers.

This state priority to utilize telehealth across Title V program will be retired since it has been fully achieved. Telehealth during the pandemic became an even greater priority, especially meeting the challenge to improve reliable internet access to rural and low-income populations as well as access to electronic devices.

A new state priority to expand telehealth services to Hawaii's underserved communities through public libraries is being added this year.

III.F. Public Input

The Family Health Services Division (FHSD) involves communities, stakeholders, and program participants including families in policy and program decision-making at many levels. Integrating public input into the Title V MCH Block Grant is critical to assure alignment with our partners to strengthen our collective impact. Consumer input also ensures Title V efforts are effective with the populations we serve. Input on Title V performance and strategy measures is collected continuously throughout the year. Since much of the Title V work is done in partnership, community collaboratives help select strategies and assist with implementation and evaluation.

Because FHSD does not use Title V funds to fund local health departments or community-based providers, there are no stakeholders with a vested interest in Title V as a funding source. Most FHSD partners are aware of the importance of Title V funding to support FHSD programs and services provided to the community especially those who also receive HRSA/MCH Bureau funding.

In FY 2020, FHSD was fortunate to hire an Information Specialist a few months before the pandemic. Prior to the pandemic, communications plans consisted of updating the FHSD program website, which includes the Title V page, and providing assistance to help bolster public input efforts. The pandemic focused attention toward media releases/messaging campaigns about the status of FHSD program service availability (including WIC services); information on support services to help families with immediate needs; health messaging to address needs during the pandemic; and information/updates on COVID-related safety issues.

There was limited opportunity to engage families during the pandemic on Title V activities as parents' needs focused on adjusting to the shutdown of businesses, work sites, schools, and childcare services. Family concerns shifted dramatically to COVID safety issues, securing income/housing aid, and schooling/caring for children. This shift in family priorities is reflected in a general reduction of Title V direct clients services in FY 2020, with key exceptions like WIC services. In a survey of FHSD program managers, most reported a reduction in client engagement in 2020.

In the same survey, FHSD program managers reported an overall increase in partnership engagement with community program and agency partners. During the pandemic, service and public health programs mobilized and coordinated efforts in response to the changing service needs of families. Modifications were made to collaborative plans, activities, public events, service contracts, and meetings. There was exponential growth in the number of virtual webinars and meetings designed to share informational updates, coordinate planning, and provide trainings to respond to emerging health concerns and issues.

Community Input for Specific Strategies and Measures

Examples of community input/coordination during COVID that changed elements of the Title V five-year plan strategies follow.

NPM 1 Women's Wellness Visits: The work for this priority is conducted in partnership with the Hawaii Maternal and Infant Health Collaborative (HMIHC), comprised of over 120 participants including physicians, clinicians, public health professionals, community service providers, insurance representatives, and healthcare administrators. The annual HMIHC meeting was canceled, and the Pre/Inter-Conception Workgroup changed its in-person meetings to use Zoom. New concerns included preparing pregnant women for new restrictions at birthing hospitals for delivery during the pandemic, cancelling of birthing education classes, and continuing to assure access to contraception and reproductive life planning.

NPM 4 Breastfeeding: The State Breastfeeding Strategic Planning Workgroup developed breastfeeding safety

messaging with the release of the COVID-19 vaccinations in response to a request from the DOH Emergency Management education/outreach staff. Vaccine providers received numerous questions from the public.

NPM 6 Developmental Screening: The Developmental Screening program organized a diverse statewide network of partners and uses this network to gather ongoing feedback. The developmental screening guidelines were reviewed to ensure the practices remained appropriate with the change to virtual/telephonic provider visits. Additionally, the Title V Early Childhood Systems Coordinator responded to requests by early childhood providers to arrange for a live webinar with the State Epidemiologist to present an update on the COVID-19 virus and newly announced CDC/DOH childcare safety protocols, with an opportunity to respond to provider questions.

NPM 10 Adolescent Health: The Adolescent Health Unit (AHU) continued to collect input from youth throughout the pandemic, working with the Coalition for Drug-Free Hawaii (CDFH) youth network. A youth survey was conducted early in the pandemic to help design health messaging for the youth group's TeenLink website and toolkit.

Survey findings indicated more resources and support were needed for mental health issues like depression, how to manage stress, and the importance of sleep. Social media was reported as the best way to meet the need for easier access to health information. Anonymous online access with ease of use was cited as highly desired, including a secure website where questions can be asked and answered anonymously. Teens also cited other modes of information that are useful from classes to resources through school, email, and special events. While there is not a single mode of communication that is needed, data suggests that what will work best is a multipronged approach from which teens are able to select information for themselves and others.

NPM 12 Transition to Adult Care: The CSHN Branch continued to collect input from youth and families on transition information and planning tools. Based on the input collected, CSHNB will explore revising the printed materials and PDFs to interactive digital apps and formats. CSHNB staff also worked with the Adolescent Health program to partner with the CDFH youth network youth conduct, a survey on teens' knowledge about their healthcare and the need for transition. The survey results will be available later in FY 2021.

SPM 4 Child Abuse and Neglect: CAN prevention has two primary mechanisms for community input including: 1) The Hawaii Children's Trust Fund (HCTF) Advisory Committee (eleven private and public members), and 2) The HCTF Coalition with 30 active members representing key community partners working to prevent child maltreatment across the islands. These groups serve a range of consumers and participate in their respective membership to be a voice for their communities.

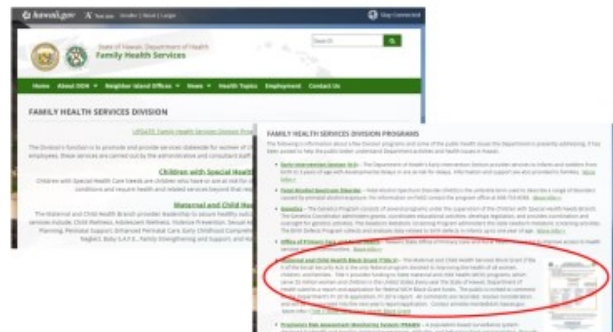
Public Access to the Title V Report/Application

The Title V 2019 Report and 2021 Application, as well as the Title V Quick Factsheet are posted on the FHSD website

(<https://health.hawaii.gov/fhds/home/title-v-maternal-child-health-block-grant/>).

The Hawaii Title V website also archives the presentations and videos used during past years' block grant reviews.

Following the submission of the 2020 Title V Report and 2022 application, FHSD will post the final document on the DOH website.



Comments can be submitted throughout the year through a return email function on the website. No comments were received on the report submitted in FY 2019.

III.G. Technical Assistance

Hawaii relies on national and local technical assistance (TA) to develop leadership and core public health skills and competencies. Our efforts to explore opportunities were largely delayed in 2020 due to COVID.

In 2020, Hawaii continued to utilize TA informational supports provided by the Maternal Child Health Bureau (MCHB), Association of Maternal and Child Health Programs (AMCHP), and Georgetown University Evidence Center. Supports include Title V learning labs; consultation with program officers and subject matter experts; Region IX conference calls; national partnership conferences; and networking with other state Title V coordinators.

Hawaii also participated in the Fall 2020 MCH Workforce Development Center Strategic Skills Session. SSDI funds were also used for a short consultation with Karen Treiweiller, MCH consultant, to explore a process to update/revise FHSD's organizational vision and mission; however, these efforts were also postponed due to COVID.

In FY 2022, FHSD hopes to conduct an employee survey to assess staff training needs and supports. TA requests will be submitted based on those results.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [Title V-Medicaid IAA MOU.pdf](#)

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [Map of health care facilities and shortage need areas.pdf](#)

Supporting Document #02 - [FHSD_Program_Description.pdf](#)

Supporting Document #03 - [Glossary of Terms.pdf](#)

Supporting Document #04 - [Needs Assessment Supporting Docs.pdf](#)

Supporting Document #05 - [Logic Models.pdf](#)

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [DOH FHSD Org Charts.pdf](#)

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Hawaii

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 2,319,160	
A. Preventive and Primary Care for Children	\$ 840,886	(36.2%)
B. Children with Special Health Care Needs	\$ 962,503	(41.5%)
C. Title V Administrative Costs	\$ 0	(%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 1,803,389	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 29,759,413	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 18,474,919	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 48,234,332	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 11,910,549		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 50,553,492	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	\$ 40,729,830	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 91,283,322	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Program (CBCAP)	\$ 486,403
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 160,020
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 250,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS)	\$ 255,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Genetic Services Project	\$ 600,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 3,588,988
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Newborn Screening State Evaluation Program	\$ 150,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	\$ 165,389
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 100,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 29,307,713
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 2,333,044
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 297,297
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	\$ 400,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 245,000

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Health	\$ 230,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Medicare Rural Hospital Flexibility Program	\$ 446,074
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospital Improvement Program	\$ 128,360
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Grant- ARPA of 2021	\$ 1,001,179
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > American Rescue Plan Act Funding for Home Visiting	\$ 334,763

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 2,077,106		\$ 2,055,426	
A. Preventive and Primary Care for Children	\$ 626,263	(30.2%)	\$ 686,365	(33.3%)
B. Children with Special Health Care Needs	\$ 816,576	(39.3%)	\$ 840,469	(40.8%)
C. Title V Administrative Costs	\$ 72,424	(3.5%)	\$ 79,665	(3.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 1,515,263		\$ 1,606,499	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 31,499,929		\$ 26,944,383	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 203,441		\$ 49,934	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 13,584,510		\$ 8,622,714	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 45,287,880		\$ 35,617,031	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 11,910,549				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 47,364,986		\$ 37,672,457	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 45,765,848		\$ 30,928,565	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 93,130,834		\$ 68,601,022	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community-Based Child Abuse Prevention Program (CBCAP)	\$ 415,271	\$ 400,870
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 29,930,606	\$ 22,145,104
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Genetic Services Project	\$ 600,000	\$ 569,383
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS)	\$ 426,600	\$ 387,633
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	\$ 165,389	\$ 160,943
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 100,000	\$ 104,052
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 236,913	\$ 358,984
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 250,000	\$ 207,200
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 157,000	\$ 157,469
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 370,000	\$ 276,462
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 297,297	\$ 290,460
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	\$ 400,000	\$ 436,466

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	\$ 0	\$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Zika Surveillance Systems Grant Program	\$ 0	\$ 8,261
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 7,388,195	\$ 2,550,036
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Rural Health	\$ 179,270	\$ 163,703
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 2,000,000	\$ 0
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 2,301,533	\$ 2,251,089
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Medicare Rural Hospital Flexibility Program	\$ 446,074	\$ 317,426
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Small Rural Hospital Improvement Program	\$ 101,700	\$ 118,660
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Coronavirus State Hospital Improvement Program		\$ 22,253
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Newborn Screening State Evaluation Program		\$ 2,111

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	Field Name:	Federal Allocation, C. Title V Administrative Costs
	Fiscal Year:	2022
	Column Name:	Application Budgeted
	Field Note: From SFY 2022 moving forward, FHSD received legislative permission to change the means of financing for the FHSD Administrative Officer V position which was the attributing expense for the Title V Administrative Costs in recent years. FHSD will budget \$0 for administrative costs from FY 2022 for the foreseeable future.	
2.	Field Name:	Federal Allocation, C. Title V Administrative Costs:
	Fiscal Year:	2020
	Column Name:	Annual Report Expended
	Field Note: This expense was 100% attributed to the salary of our Administrative Officer V position salary. From FY 2022 forward, this position will change funding sources and the Title V Administrative Costs are projected to become \$0.	
3.	Field Name:	3. STATE MCH FUNDS
	Fiscal Year:	2020
	Column Name:	Annual Report Expended
	Field Note: The budgeted amount \$31,499,929 was based on the SFY 20 Hawaii legislative authorized budget ceiling for overall operating and personnel costs. The authorized budget ceiling is normally higher than the actual expenditures which is often affected by position vacancies and changes or reduction in contractual execution and performance.	
4.	Field Name:	5. OTHER FUNDS
	Fiscal Year:	2020
	Column Name:	Annual Report Expended
	Field Note: The budgeted amount was based on the legislative authorized ceiling however funds for the Child Death Review project discontinued in SFY 20 resulting in low income and low expenditures.	
5.	Field Name:	6. PROGRAM INCOME
	Fiscal Year:	2020
	Column Name:	Annual Report Expended

Field Note:

A similar explanation as noted for FY 19 program income/expenditure discrepancy. The budgeted amount for program income was \$13,584,510 but expenditures were only \$8,622,714. The reason for the difference is that the authorized budget ceilings for the Community Health Centers Special Fund, Early Intervention Special Fund, and the Domestic Violence and Sexual Assault Special Fund is higher than the revenues being deposited into these accounts. Annual expenditures are roughly aligned with the revenues being deposited and are not aligned with the authorized budget ceilings for these special fund accounts. The legislative authorized ceiling will continue to differ from actual expenditures moving forward.

6. **Field Name:** 7. TOTAL STATE MATCH

Fiscal Year: 2020

Column Name: Annual Report Expended

Field Note:

Similar to comments regarding Program Income budget/expenditures, the Total State Match budgeted includes the legislative budget ceiling for general and special funds. Actual expenditures are usually lower due to a more accurate reflection of expenditures based on program revenue with vacancy savings and contract performances taken into account.

7. **Field Name:** Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants

Fiscal Year: 2020

Column Name: Annual Report Expended

Field Note:

The discrepancy in budgeted vs. expended for the MIECHV grant can be attributed to the difference in the legislative authorized ceiling (budget) for the MIECHV grant contrasted with actual contract expenditures. Delays in contract execution coupled with limited/reduced contract activities in FY 2020 due to COVID-19 accounts for the large discrepancy.

8. **Field Name:** Other Federal Funds, Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning

Fiscal Year: 2020

Column Name: Annual Report Expended

Field Note:

From SFY 2019, due to proposed changes the Hawaii Governor decided to join a multi-state lawsuit to challenge the new Title X rules. As a result, Hawaii is no longer a Title X grantee. Although FHSD budgeted \$2M, there were \$0 expenditures in FY2020.

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served
State: Hawaii

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	\$ 201,754	\$ 182,205
2. Infants < 1 year	\$ 193,316	\$ 202,204
3. Children 1 through 21 Years	\$ 840,886	\$ 686,365
4. CSHCN	\$ 962,503	\$ 840,469
5. All Others	\$ 120,701	\$ 64,518
Federal Total of Individuals Served	\$ 2,319,160	\$ 1,975,761

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	\$ 6,105,662	\$ 4,385,052
2. Infants < 1 year	\$ 4,587,258	\$ 3,010,279
3. Children 1 through 21 Years	\$ 5,065,807	\$ 3,443,560
4. CSHCN	\$ 26,094,527	\$ 20,176,115
5. All Others	\$ 6,345,304	\$ 4,602,025
Non-Federal Total of Individuals Served	\$ 48,198,558	\$ 35,617,031
Federal State MCH Block Grant Partnership Total	\$ 50,517,718	\$ 37,592,792

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	Field Name:	FEDERAL-STATE MCH BLOCK GRANT PARTNERSHIP TOTAL
	Fiscal Year:	2022
	Column Name:	Application Budgeted

Field Note:

The increase in FY 2022 budged vs. FY 2020 expended is due to the change in methodology from FY 2021 to calculate Program Income based on the legislative authorized ceiling. This variance in budgeted vs. expended is reflected in each of the budgeted vs. expended categories above. The disparity will continue in future applications until the authorized ceiling becomes a more accurate representation of actual expenditures.

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services
State: Hawaii

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	\$ 0	\$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 0	\$ 0
B. Preventive and Primary Care Services for Children	\$ 0	\$ 0
C. Services for CSHCN	\$ 0	\$ 0
2. Enabling Services	\$ 108,868	\$ 102,698
3. Public Health Services and Systems	\$ 2,210,292	\$ 1,952,728
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 0
Physician/Office Services		\$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Direct Services Line 4 Expended Total		\$ 0
Federal Total	\$ 2,319,160	\$ 2,055,426

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	\$ 25,997,293	\$ 16,650,302
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 1,184,579	\$ 1,072,527
B. Preventive and Primary Care Services for Children	\$ 11,857,390	\$ 4,718,122
C. Services for CSHCN	\$ 12,955,324	\$ 10,859,653
2. Enabling Services	\$ 12,236,121	\$ 10,019,840
3. Public Health Services and Systems	\$ 9,965,144	\$ 8,076,701
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 0
Physician/Office Services		\$ 1,335,020
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 911,100
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Other		
Primary and Urgent Care in Hana		\$ 1,130,000
Waianae Coast Emergency Room Services		\$ 1,796,433
Early Intervention Services (POS)		\$ 11,477,749
Direct Services Line 4 Expended Total		\$ 16,650,302
Non-Federal Total	\$ 48,198,558	\$ 34,746,843

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	Field Name:	IIB. Non-Federal MCH Block Grant, Non-Federal Total Budgeted
	Fiscal Year:	2022
	Column Name:	Application Budgeted

Field Note:

The FY 2022 budget for Non-Federal MCH Block Grant direct services is nearly \$9,346,991 more than was expended in FY 2020. The increase can primarily be attributed to the change in methodology of calculating program income allocated to direct services. The budget reflects the legislative authorized ceiling whereas expenditures are actual.

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated
State: Hawaii

Total Births by Occurrence: 15,780

Data Source Year: 2020

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	15,728 (99.7%)	1,333	34	34 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methylglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-CoA Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-CoA Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-CoA Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, β -Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiencies	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
β -Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Children are monitored for at least a year or longer (up to 21 years old) if needed. Length of time depends on medical condition, health status of child, and social or other issues. This is done by the NBMS staff; CSHNB nurses, nutritionist, or social workers, or public health nurses.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Hawaii

Annual Report Year 2020

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	902	34.0	0.0	63.0	3.0	0.0
2. Infants < 1 Year of Age	339	34.0	0.0	63.0	3.0	0.0
3. Children 1 through 21 Years of Age	12,519	30.0	0.0	66.0	4.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	8,033	29.0	0.0	68.0	3.0	0.0
4. Others	24,312	13.0	0.0	83.0	4.0	0.0
Total	38,072					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	16,797	No	15,780	99.0	15,622	902
2. Infants < 1 Year of Age	16,827	No	15,780	100.0	15,780	339
3. Children 1 through 21 Years of Age	347,214	Yes	347,214	43.0	149,302	12,519
3a. Children with Special Health Care Needs 0 through 21 years of age^	50,234	Yes	50,234	23.0	11,554	8,033
4. Others	1,051,858	Yes	1,051,858	47.0	494,373	24,312

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2020
Field Note: Programs that contributed to this count include pregnant women who received Perinatal Support Services (provides support for pregnant women who may be at risk for poor birth outcomes, provides case management support services, health education and other resources needed to increase the likelihood of positive birth outcomes; 902). The percentages of primary source of coverage are based on 2019 National Vital Statistics System for Pregnant Women/Infants. Note that the minor decline from 2019 (933) might be due to the 2020 COVID pandemic emergency shutdown orders and the change of service delivery from in-person to virtual services.		
2.	Field Name:	Infants Less Than One YearTotal Served
	Fiscal Year:	2020
Field Note: Programs that contributed to this count of infants < 1 year of age include 2020 Primary Care Contracts (305). Primary Care Contracts are state funded for safely net providers including Federally Qualified Health Centers to provide services for the uninsured/underinsured. The community health center contracts provide comprehensive medical and health care services (perinatal, pediatric, adult primary care) and support services to uninsured and underinsured individuals that are at or below two hundred fifty percent (250%) of the Federal poverty level. Access to primary health services reduces morbidity and mortality by providing timely, appropriate, and less expensive care, and thereby prevent the development and exacerbation of serious health conditions. Additionally, there was no way to differentiate the primary source of coverage for those that were provided services through the underinsured due to lack of access to the data. Other programs that contributed to this count include Family Strengthening Program [home reach (provides in-home parent education and support services to promote the five protective factors which have been shown to strengthen families; 34)]. Note. The percentages of primary source of coverage are based on 2019 American Community Survey for Children 1-21. Note that the decline from 2019 (544) might be due to the 2020 COVID pandemic emergency shutdown orders and the change of service delivery from in-person to virtual services.		
3.	Field Name:	Children 1 through 21 Years of Age
	Fiscal Year:	2020

Field Note:

Programs that contributed to this count include 2020 Primary Care Contracts (1,219), which are state funded for safely net providers including Federally Qualified Health Centers to provide services for the uninsured/underinsured. The community health center contracts provide comprehensive medical and health care services (perinatal, pediatric, adult primary care) and support services to uninsured and underinsured individuals that are at or below two hundred fifty percent (250%) of the Federal poverty level. Other programs that contributed to this count include Family Planning Services (assists individuals in determining the number and spacing of their children and promotes positive birth outcomes and health families; 100% State Contribution; 2,973), Family Strengthening Programs [Community Based Parenting Education (provides a statewide, community-based, comprehensive parenting education and support groups utilizing an evidence-based/evidence-informed, to promote the five protective factors which have been shown to strengthen families; 212), Home Reach (provides in-home parent education and support services to promote the five protective factors which have been shown to strengthen families; 82)], and Children with Special Health Care Needs in 3a (8,033). Note that Children the count for Community Based Parenting Education (212) includes infants < 1 year as there was no way to separate the count between the two groups.

Note. Family Planning Services changed from 40% state funded to 100% state funded since April 2019. The percentages of primary source of coverage are based on 2019 American Community Survey for Children 1-21.

Note that the decline from 2019 (13,130) might be due to the 2020 COVID pandemic emergency shutdown orders and the change of service delivery from in-person to virtual services.

4.	Field Name:	Children with Special Health Care Needs 0 through 21 Years of Age
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Fiscal Year:	2020
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Field Note:

2020 data for the number of children serviced contributed by CSHNB (8,033). Programs that contributed to the count include Family Strengthening Program [Home Reach (provides in-home parent education and support services; 2)]; Children with Special Health Needs Section (provides care coordination and other services for children age 0-21 with chronic medical conditions; 579); genetics, metabolic, hemoglobinopathy, Neighbor Island genetics, telemedicine clinics (provides provides genetic services, information, and education; 1,225); Newborn Metabolic Screening Program follow-up (detect rare disorders that can cause serious health and development problems; 1,373); Newborn Hearing Screening Program follow-up (identify hearing loss early so children can receive timely early intervention services; 511); Early Intervention Section (provides care coordination, family training, etc for children age 0-3 with developmental delay or at biological risk; 3,598); Hi'ilei Developmental Screening Program (provides developmental screening via mail or online, and activities to help in children's development; 38); Hawaii Childhood Lead Poisoning Prevention follow-up (aims to reduce children's exposure to lead by strengthening blood lead testing; 237); and Early Childhood Comprehensive Systems developmental screening (developmental screening of 3 year olds in Maui County; 470). The distribution of source of coverage is based on National Survey of Children's Health – CSHCN, 2018-2019

Note that developmental screening increased from 2019 (118) was because the increased number of screens administered per child by the program. The increase in NBMSPP from 2019 (1,094) was due to the change in the contracted laboratory which result in changes in operation.

5.	Field Name:	Others
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Fiscal Year:	2020
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Field Note:

Programs that contributed to this count of others include 2020 Primary Care Contracts (12,839). The count also included Family Planning Services (assists individuals in determining the number and spacing of their children and promotes positive birth outcomes and health families; 100% State Contribution; 8,069), Family Strengthening Programs [Community Based Parenting Education (provides a statewide, community-based, comprehensive parenting education and support groups utilizing an evidence-based/evidence-informed, to promote the five protective factors which have been shown to strengthen families; 718), Safe Sleep (provides safe sleep education and play yards to promote safe sleep practices consistent with the American Academy of Pediatric guidelines to decrease infant mortality related to sleeping; 68), Home Reach (provides in-home parent education and support services to promote the five protective factors which have been shown to strengthen families; 55), Parent Line (provides comprehensive parenting education, training, and support through a telephone warmline, a website, and printed and electronic educational resources; number of calls received on the State MCH Hotline=1,293)], Kauai District Health Office (COVID test, contact tracing, vaccination; 300), and Maui District Health Office (COVID 19 Vaccination POD/Clinic, COVID-19 Investigation and Contact Tracing; 470), and number of contact tracing calls made by CSHNB staff (500). Note. Family Planning Services changed from 40% state funded to 100% state funded since April 2019. The percentages of primary source of coverage are based on 2018 American Community Survey for adults 22+.

Note that the decline from 2019 (24,447) might be due to the 2020 COVID pandemic emergency shutdown orders and the change of service delivery from in-person to virtual services.

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women
	Fiscal Year:	2020
	Field Note: Numerator : Estimated by the percentage of pregnant women who received safe sleep education messages at the hospital (99%). Note. Other programs that served pregnant women included 5a number (3,302), number of brochures distributed to pregnant women (4,900; may be duplicated as each woman may receive more than one brochure), women who receive mailout resources from PRAMS program (2400), WIC Program (5,881), and Home Visiting Program (a family support program for pregnant women, mothers, & children under the age of 5 providing regular visits to families to encourage maternal & child health; prevention of child abuse & neglect; promotion of child development & school readiness; promotion of positive parenting practices; and information/referrals to healthcare and community resources; 58).	
2.	Field Name:	InfantsLess Than One Year
	Fiscal Year:	2020
	Field Note: Estimated by 2020 percentage of newborn metabolic screening (99.7%) Note. Other programs that served infants included Kauai District Health Office (400), Home Visiting (a family support program for pregnant women, mothers, & children under the age of 5 providing regular visits to families to encourage maternal & child health; prevention of child abuse & neglect; promotion of child development & school readiness; promotion of positive parenting practices; and information/referrals to healthcare and community resources; 197), Family Strengthening Program (Parent Line, 43), and WIC (11,326).	

3.	Field Name:	Children 1 Through 21 Years of Age
	Fiscal Year:	2020
	<p>Field Note:</p> <p>Numerator: Programs contributed to the numerator (150,304) included 5a number (4,486), Parent Line (Line provides comprehensive parenting education, training, and support through a telephone warmline, a website, and printed and electronic educational resources; 724), Participation in WIC Program (state provided administrative support, 17,605), Adolescent Health (serves 11-24 years old in programs such as Youth Challenge Academy, Personal Responsibility Education Program etc; 572), Project ECHO Hawaii Pediatric Series (a guided-practice model that reduces health disparities in underserved and rural areas through the use of a hub-and-spoke approach where expert teams lead virtual clinics; 143), Kauai District Health Office (services included promotion of child abuse and neglect prevention via newspaper articles, large public banner in main town square etc; 4,500), Home Visiting (a family support program by providing regular visits to families to promote positive parenting practices; 364), Safe Sleep (messaging campaigns safe sleep in licensed childcare sites; 6,500), Sexual Violence Prevention Program (provides primary prevention services through statewide partnerships to prevent all forms of sexual violence and promote healthy, respectful relationships; 103,977), and Children with Special Health Care Needs (11,433).</p> <p>Note. The large increase in the Sexual Violence Prevention Program (103,977) compared to 2019 data (9,734) was due to this activity conducted by the program: The Honolulu Theatre for Youth created a "[Respect]" episode to share messages related to sexual violence prevention for youth and their families. The episode aired five times and received 103,423 views on KHNL.</p> <p>Denominator: 2019 Census Estimate (347,214)</p>	
4.	Field Name:	Children with Special Health Care Needs 0 through 21 Years of Age
	Fiscal Year:	2020
	<p>Field Note:</p> <p>Programs that contributed to the count include 5a number (8,033). An estimated 7% of the CYSHCN population (3,400) was reached through various community events and websites with CSHNB educational outreach for newborn metabolic screening, developmental screening, childhood lead poisoning prevention, early intervention services, transition to adult health care, telehealth, and other CYSHCN topics. The denominator was based on reference data provided.</p>	
5.	Field Name:	Others
	Fiscal Year:	2020

Field Note:

Numerator: Programs contributed to the numerator (496,445) included 5a number (24,312); Sexual Violence Prevention Program (The Honolulu Theatre for Youth "[Respect]" episode, community meetings and training; 1,929), Adolescent Health (training for teen-serving staffs; 747), WIC services for postpartum women (6,195); Hawaii Public Health Training Hui (education to promote health and well-being; 2,672), Parent Leadership Training Institute (PLTI) Hawaii (increases the number and skill level of parents and community leaders; 25), Kauai District Health Office (1,000), Hawaii Medicare Rural Hospital Flexibility Program (Clinical Quality and Financial Improvement Training to critical access hospital staff; 81), Oral Health (oral health meetings, 50), Domestic Violence Prevention Program (workforce trainings; 3225), Child Abuse/Neglect Prevention (events on raising awareness of child abuse and neglect prevention; 786), and Parenting Support/Safe Sleep (210), Home Visiting Network (outreach campaigns; 507), CMV brochures distributed to adults by the Perinatal program (420), the Parent Line Media Campaign (Statewide TV and digital campaign promoting family strengthening and violence prevention during COVID-19 through a warmline and website, 440,087), Hawaii eWIC Launch (Promoted new electronic benefits with a news release, 7,500), and COVID work (conference calls on COVID outbreak and distribution of COVID protocols; 5,500).

Note that the decline in Safe Sleep from 2019 (8,250; estimated number of family members of newborns receiving safe sleep education at the time of delivery) to 2020 (210; number of guides distributed to new licensed facilities and statewide during annual visits) was due to a different approach in obtaining the counts.

Also note the significant increase in adults served from 4% (2019) to 47.2% (2020) is due to the Parent Line Media Campaign which reached 440,087 people.

Denominator: 2019 Census Estimate (1,051,858).

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Hawaii

Annual Report Year 2020

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non- Hispanic White	(C) Non- Hispanic Black or African American	(D) Hispanic	(E) Non- Hispanic American Indian or Native Alaskan	(F) Non- Hispanic Asian	(G) Non- Hispanic Native Hawaiian or Other Pacific Islander	(H) Non- Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	15,500	3,925	361	2,572	8	3,873	1,548	3,049	164
Title V Served	15,452	3,913	360	2,564	8	3,861	1,543	3,039	164
Eligible for Title XIX	10,402	1,258	141	734	236	3,404	2,361	0	2,268
2. Total Infants in State	16,799	2,490	260	2,847	30	3,617	2,121	5,434	0
Title V Served	16,749	2,483	259	2,838	30	3,606	2,115	5,418	0
Eligible for Title XIX	15,598	237	82	380	62	823	318	0	13,696

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	Field Name:	1. Total Deliveries in State
	Fiscal Year:	2020
	Column Name:	Total
	Field Note: Information obtained from maternal race as reported in 2020 vital statistics birth certificate data. The number of more than single birth (twin, triplet) is subtracted from the number of births.	
2.	Field Name:	1. Title V Served
	Fiscal Year:	2020
	Column Name:	Total
	Field Note: Used overall estimate of newborn metabolic screening percentage (99.7%) in 2020 applied to overall total and each race group.	
3.	Field Name:	1. Eligible for Title XIX
	Fiscal Year:	2020
	Column Name:	Total
	Field Note: Data Source: Data from Hawaii Medicaid program in 2020 and reflects unduplicated clients served. Note. Collection of race differs between that reported for Title V served and those reported for Title XIX so are not directly comparable. For example, the number of clients of more than one race was not provided by the Hawaii Medicaid Program. Note that the decrease in number in 2020 (10,402) when compared to 2019 data (21,069) is due to a more conservative methodology used in data collection described as follows: For 2019, the query was based on diagnosis codes only. Pregnant women were identified as women with one or more claims or encounters with a service date between 1/1/2019 and 12/31/2019 with any of these diagnostic codes listed as primary or secondary: O09, O1, O2, O3, O4, O6, O7, O80, O82, O98, O99, O9A, Z33, Z34, Z36, Z37, Z38. All available form types were examined. For 2020, the number of women who had a “live birth” between 1/1/2020 and 12/31/2020 was examined. This was a definitive way to count the number of covered pregnant women who had a live birth. Given that not all pregnancies have this outcome, our pregnancy eligibility category was also examined. Medicaid has pregnancy-specific eligibility criteria so those that had this status at any point throughout the year were included.	
4.	Field Name:	2. Total Infants in State
	Fiscal Year:	2020
	Column Name:	Total

Field Note:

Total number of infants based on 2019 CDC, NCHS, Bridged-Race population estimates from <https://wonder.cdc.gov>. 2020 information is not available yet. The Bridged-Race population groups reported are different from that requested in Title V. To determine race specific estimates for Title V, the distribution of race based on children under 5 years based on 2010 Census was applied to total infants in state as more current data was not available for requested race groups. Additionally, American Community Survey does not report out single year age estimates. Note: Collection of race varies from that reported from vital statistics so not directly comparable. For example, more than one race reported was not available from data requested.

5.	Field Name:	2. Title V Served
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Fiscal Year:	2020
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Column Name:	Total
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Field Note:

Based on the proportion of infants receiving newborn metabolic screening (99.7% in 2020)

6.	Field Name:	2. Eligible for Title XIX
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Fiscal Year:	2020
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Column Name:	Total
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Field Note:

Data source: Data from Hawaii Medicaid program in 2020 and reflects unduplicated clients served. Note. Collection of race differs between that reported for Title V served and those reported for Title XIX so are not directly comparable. For example, the number of clients of more than one race was not provided by the Hawaii Medicaid Program.

Note that The number in 2020 (15,598) is slightly higher than those reported in 2019 (14,083). The higher enrollment is because Medicaid has not conducted typical disenrollments since the beginning of the public health emergency. We anticipate that these numbers will decline slightly once the public health emergency has ended.

Also note that the number of infants exceeds the number of pregnant women. This is because infants are defined as all children <1 year old in 2020, which will include most or all births over a period of two years.

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Hawaii

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 816-1222	(800) 816-1222
2. State MCH Toll-Free "Hotline" Name	The Parent Line	The Parent Line
3. Name of Contact Person for State MCH "Hotline"	Casee Segovia	Casee Segovia
4. Contact Person's Telephone Number	(808) 681-1541	(808) 681-1541
5. Number of Calls Received on the State MCH "Hotline"		1,293

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names	Early Intervention Referral Line	Early Intervention Referral Line
2. Number of Calls on Other Toll-Free "Hotlines"		2,912
3. State Title V Program Website Address	http://health.hawaii.gov/fhsd	http://health.hawaii.gov/fhsd
4. Number of Hits to the State Title V Program Website		1,662
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information
State: Hawaii

1. Title V Maternal and Child Health (MCH) Director

Name	Matthew J. Shim, Ph.D., M.P.H.
Title	Chief, Family Health Services Division
Address 1	1250 Punchbowl Street, Room 216
Address 2	
City/State/Zip	Honolulu / HI / 96813
Telephone	(808) 586-4122
Extension	
Email	matthew.shim@doh.hawaii.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Patricia Heu, M.D
Title	Chief, Children with Special Health Needs Branch
Address 1	741 Sunset Avenue
Address 2	CSHNP
City/State/Zip	Honolulu / HI / 96816
Telephone	(808) 733-9070
Extension	
Email	patricia.heu@doh.hawaii.gov

3. State Family or Youth Leader (Optional)

Name	Leolinda Iokepa
Title	Director, Hilopaa Family to Family Information
Address 1	1319 Punahou St. Ste 739
Address 2	
City/State/Zip	Honolulu / HI / 96816
Telephone	(808) 791-3467
Extension	
Email	leo@hilopaa.org

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Hawaii

Application Year 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five- year reporting period)
1.	Promote reproductive life planning	Continued
2.	Increase the rate of infants sleeping in safe conditions	Revised
3.	Improve the percentage of children screened early and continuously ages 0-5 years for developmental delay	Continued
4.	Reduce the rate of confirmed child abuse and neglect cases per 1,000 with special attention to children ages 0-5 years.	Revised
5.	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	Continued
6.	Improve the healthy development, health, safety, and well-being of adolescents	Continued
7.	Reduce food insecurity for pregnant women and infants through WIC program promotion and partnerships	New
8.	Promote child wellness visits and immunizations among young children ages 0-5 years.	New
9.	Address health equity and disparities by expanding pediatric mental health care access in rural and under-served communities	New
10.	Address health and digital equity by expanding access to telehealth information and services in state public libraries located in underserved communities.	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Promote reproductive life planning	Continued
2.	Increase the rate of breastfeeding	Revised
3.	Increase the rate of infants sleeping in safe conditions	Revised
4.	Improve the percentage of children screened early and continuously ages 0-5 years for developmental delay	Continued
5.	Reduce the rate of confirmed child abuse and neglect cases per 1,000 with special attention to children ages 0-5 years.	Revised
6.	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	Continued
7.	Improve the healthy development, health, safety, and well-being of adolescents	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Hawaii

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	72.0 %	0.4 %	11,377	15,800
2018	72.5 %	0.4 %	11,920	16,433
2017	76.5 %	0.3 %	12,515	16,355
2016	75.9 %	0.3 %	13,232	17,426
2015	77.2 %	0.3 %	13,650	17,680
2014	77.9 %	0.3 %	13,696	17,578

Legends:

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None


Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	104.3	8.6	149	14,281
2017	84.7	7.6	124	14,648
2016	87.9	7.7	132	15,010
2015	66.8	7.7	76	11,376
2014	76.8	7.2	116	15,112
2013	54.8	6.0	85	15,516
2012	60.8	6.3	95	15,633
2011	59.7	6.2	93	15,567
2010	52.0	5.8	81	15,585
2009	55.6	6.0	88	15,823
2008	61.0	6.2	99	16,225

Legends: Indicator has a numerator ≤10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 2 - Notes:**

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2019	14.8 ⚡	4.1 ⚡	13 ⚡	87,765 ⚡
2014_2018	13.4 ⚡	3.9 ⚡	12 ⚡	89,518 ⚡

Legends:

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data

	2020
Annual Indicator	11.7
Numerator	10
Denominator	85,198
Data Source	Vital Statistics
Data Source Year	2016-2020

NOM 3 - Notes:

None


Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	8.4 %	0.2 %	1,410	16,784
2018	8.3 %	0.2 %	1,416	16,966
2017	8.5 %	0.2 %	1,491	17,508
2016	8.5 %	0.2 %	1,537	18,045
2015	8.3 %	0.2 %	1,531	18,392
2014	7.9 %	0.2 %	1,462	18,526
2013	8.2 %	0.2 %	1,562	18,970
2012	8.1 %	0.2 %	1,542	18,975
2011	8.2 %	0.2 %	1,557	18,947
2010	8.3 %	0.2 %	1,584	18,972
2009	8.4 %	0.2 %	1,592	18,872

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution**NOM 4 - Notes:**

None


Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	10.6 %	0.2 %	1,775	16,785
2018	10.3 %	0.2 %	1,744	16,960
2017	10.4 %	0.2 %	1,829	17,508
2016	10.5 %	0.2 %	1,904	18,053
2015	10.1 %	0.2 %	1,861	18,409
2014	10.0 %	0.2 %	1,862	18,537
2013	10.2 %	0.2 %	1,928	18,959
2012	9.9 %	0.2 %	1,885	18,964
2011	9.9 %	0.2 %	1,880	18,938
2010	10.5 %	0.2 %	1,985	18,953
2009	11.1 %	0.2 %	2,094	18,785

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution**NOM 5 - Notes:**

None


Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	28.9 %	0.4 %	4,851	16,785
2018	28.5 %	0.4 %	4,831	16,960
2017	28.2 %	0.3 %	4,940	17,508
2016	27.8 %	0.3 %	5,022	18,053
2015	27.9 %	0.3 %	5,140	18,409
2014	27.6 %	0.3 %	5,115	18,537
2013	26.5 %	0.3 %	5,024	18,959
2012	26.4 %	0.3 %	5,012	18,964
2011	27.0 %	0.3 %	5,104	18,938
2010	26.9 %	0.3 %	5,089	18,953
2009	28.4 %	0.3 %	5,326	18,785

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution**NOM 6 - Notes:**

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	6.0 %			
2013/Q2-2014/Q1	7.0 %			

Legends:

NOM 7 - Notes:

None


Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	6.4	0.6	109	17,023
2017	6.3	0.6	111	17,573
2016	5.6	0.6	102	18,106
2015	4.9	0.5	90	18,452
2014	5.0	0.5	93	18,591
2013	6.7	0.6	128	19,038
2012	5.4	0.5	103	19,028
2011	6.0	0.6	115	19,012
2010	6.1	0.6	116	19,032
2009	6.0	0.6	114	18,935

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 8 - Notes:**

None


Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	6.8	0.6	115	16,972
2017	5.4	0.6	95	17,517
2016	6.0	0.6	109	18,059
2015	5.7	0.6	105	18,420
2014	4.5	0.5	83	18,550
2013	6.4	0.6	121	18,987
2012	4.8	0.5	92	18,980
2011	5.3	0.5	100	18,956
2010	6.2	0.6	118	18,988
2009	5.9	0.6	112	18,887

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 9.1 - Notes:**

None


Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	3.9	0.5	66	16,972
2017	3.8	0.5	67	17,517
2016	3.8	0.5	68	18,059
2015	3.6	0.5	67	18,420
2014	3.3	0.4	62	18,550
2013	4.6	0.5	87	18,987
2012	3.6	0.4	68	18,980
2011	3.6	0.4	68	18,956
2010	4.0	0.5	76	18,988
2009	4.4	0.5	83	18,887

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 9.2 - Notes:**

None


Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	2.9	0.4	49	16,972
2017	1.6	0.3	28	17,517
2016	2.3	0.4	41	18,059
2015	2.1	0.3	38	18,420
2014	1.1	0.3	21	18,550
2013	1.8	0.3	34	18,987
2012	1.3	0.3	24	18,980
2011	1.7	0.3	32	18,956
2010	2.2	0.3	42	18,988
2009	1.5	0.3	29	18,887

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 9.3 - Notes:**

None


Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	253.4	38.7	43	16,972
2017	222.6	35.7	39	17,517
2016	216.0	34.6	39	18,059
2015	228.0	35.2	42	18,420
2014	177.9	31.0	33	18,550
2013	258.1	36.9	49	18,987
2012	200.2	32.5	38	18,980
2011	200.5	32.6	38	18,956
2010	221.2	34.2	42	18,988
2009	233.0	35.2	44	18,887

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 9.4 - Notes:**

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	111.9 ⚡	25.7 ⚡	19 ⚡	16,972 ⚡
2017	NR 🚩	NR 🚩	NR 🚩	NR 🚩
2016	94.1 ⚡	22.8 ⚡	17 ⚡	18,059 ⚡
2015	76.0 ⚡	20.3 ⚡	14 ⚡	18,420 ⚡
2014	NR 🚩	NR 🚩	NR 🚩	NR 🚩
2013	79.0 ⚡	20.4 ⚡	15 ⚡	18,987 ⚡
2012	63.2 ⚡	18.3 ⚡	12 ⚡	18,980 ⚡
2011	NR 🚩	NR 🚩	NR 🚩	NR 🚩
2010	115.9	24.7	22	18,988
2009	NR 🚩	NR 🚩	NR 🚩	NR 🚩

Legends:

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution



NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	6.8 %	1.4 %	569	8,360
2015	8.7 %	1.0 %	1,522	17,555
2014	8.5 %	1.0 %	1,474	17,402
2013	7.6 %	0.9 %	1,368	18,029
2012	7.9 %	0.9 %	1,416	17,864
2011	6.9 %	0.8 %	1,267	18,437
2010	7.2 %	0.8 %	1,328	18,461
2009	6.7 %	0.8 %	1,230	18,374
2008	6.3 %	0.6 %	1,167	18,459
2007	6.0 %	0.6 %	1,107	18,342

Legends: Indicator has an unweighted denominator <30 and is not reportable Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution**NOM 10 - Notes:**

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	1.3 ⚡	0.3 ⚡	19 ⚡	14,468 ⚡
2017	2.2	0.4	32	14,879
2016	1.1 ⚡	0.3 ⚡	16 ⚡	15,111 ⚡
2015	NR 🚩	NR 🚩	NR 🚩	NR 🚩
2014	1.4	0.3	22	15,358
2013	0.8 ⚡	0.2 ⚡	12 ⚡	15,722 ⚡
2012	0.8 ⚡	0.2 ⚡	13 ⚡	15,869 ⚡
2011	0.8 ⚡	0.2 ⚡	13 ⚡	15,757 ⚡
2010	NR 🚩	NR 🚩	NR 🚩	NR 🚩
2009	NR 🚩	NR 🚩	NR 🚩	NR 🚩
2008	0.8 ⚡	0.2 ⚡	13 ⚡	16,419 ⚡

Legends:

🚩 Indicator has a numerator ≤10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	12.9 %	1.6 %	36,524	282,655
2017_2018	8.6 %	1.2 %	23,601	275,995
2016_2017	9.5 %	1.1 %	27,331	287,697
2016	10.9 %	1.4 %	32,106	295,883

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	16.8	3.3	26	155,129
2018	13.3	2.9	21	157,349
2017	18.2	3.4	29	158,951
2016	16.8	3.2	27	160,245
2015	14.4	3.0	23	160,241
2014	14.5	3.0	23	158,910
2013	20.2	3.6	32	158,268
2012	10.9 ⚡	2.7 ⚡	17 ⚡	155,558 ⚡
2011	16.8	3.3	26	154,442
2010	14.4	3.1	22	153,004
2009	19.3	3.6	29	150,364

Legends:

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None


Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	31.0	4.4	49	158,163
2018	25.1	4.0	40	159,133
2017	25.8	4.0	41	159,029
2016	33.7	4.6	54	160,416
2015	27.0	4.1	44	163,073
2014	20.9	3.6	34	162,896
2013	25.2	3.9	41	162,519
2012	27.7	4.1	45	162,427
2011	30.3	4.3	50	165,114
2010	26.9	4.0	45	167,533
2009	31.5	4.3	53	168,494

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 16.1 - Notes:**

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	6.5 ⚡	1.7 ⚡	15 ⚡	231,497 ⚡
2016_2018	8.6	1.9	20	232,911
2015_2017	11.0	2.2	26	235,446
2014_2016	10.9	2.1	26	238,506
2013_2015	9.6	2.0	23	240,137
2012_2014	8.3	1.9	20	242,273
2011_2013	11.4	2.2	28	245,750
2010_2012	11.1	2.1	28	251,412
2009_2011	12.5	2.2	32	256,302
2008_2010	11.6	2.1	30	259,537
2007_2009	10.8	2.0	28	260,274

Legends:

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution


NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	10.4	2.1	24	231,497
2016_2018	9.9	2.1	23	232,911
2015_2017	13.2	2.4	31	235,446
2014_2016	13.0	2.3	31	238,506
2013_2015	11.2	2.2	27	240,137
2012_2014	8.3	1.9	20	242,273
2011_2013	9.0	1.9	22	245,750
2010_2012	9.5	2.0	24	251,412
2009_2011	11.3	2.1	29	256,302
2008_2010	11.9	2.2	31	259,537
2007_2009	10.8	2.0	28	260,274

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 16.3 - Notes:**

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	13.8 %	1.4 %	41,505	301,627
2017_2018	13.0 %	1.2 %	39,591	304,299
2016_2017	13.4 %	1.1 %	41,238	308,059
2016	13.6 %	1.3 %	42,109	309,692

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	18.6 %	4.1 %	7,706	41,505
2017_2018	16.6 %	3.5 %	6,564	39,591
2016_2017	17.4 %	3.1 %	7,174	41,238
2016	16.7 %	3.2 %	7,021	42,109

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution


NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder**Data Source: National Survey of Children's Health (NSCH)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	2.0 %	0.5 %	4,822	243,451
2017_2018	1.7 %	0.4 %	4,176	243,788
2016_2017	1.6 %	0.4 %	4,022	254,642
2016	1.8 % ⚡	0.6 % ⚡	4,558 ⚡	257,036 ⚡

Legends: Indicator has an unweighted denominator <30 and is not reportable Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution**NOM 17.3 - Notes:**

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	6.3 %	1.2 %	15,021	239,185
2017_2018	6.4 %	1.1 %	15,515	241,777
2016_2017	5.4 %	0.8 %	13,620	253,200
2016	5.0 %	0.7 %	12,754	254,397

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	56.6 % ⚡	8.2 % ⚡	10,655 ⚡	18,809 ⚡
2017_2018	54.4 % ⚡	7.1 % ⚡	10,866 ⚡	19,992 ⚡
2016_2017	45.6 % ⚡	6.1 % ⚡	9,601 ⚡	21,033 ⚡
2016	38.4 % ⚡	7.4 % ⚡	8,494 ⚡	22,150 ⚡

Legends:

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	92.9 %	1.1 %	279,910	301,442
2017_2018	92.4 %	1.1 %	280,914	304,114
2016_2017	91.3 %	1.0 %	280,275	307,112
2016	91.7 %	1.2 %	282,105	307,798

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	10.7 %	0.3 %	1,158	10,871
2016	9.6 %	0.3 %	1,113	11,589
2014	10.3 %	0.3 %	1,343	12,987
2012	10.2 %	0.3 %	1,489	14,578
2010	9.7 %	0.3 %	1,413	14,504
2008	10.0 %	0.3 %	1,279	12,796

Legends:

🚩 Indicator has a denominator <50 and is not reportable

⚡ Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	16.4 %	1.1 %	6,757	41,208
2017	14.2 %	0.6 %	5,507	38,832
2015	12.9 %	1.1 %	5,067	39,140
2013	13.4 %	1.0 %	5,384	40,213
2011	13.2 %	1.2 %	5,550	42,116
2009	14.2 %	1.7 %	6,723	47,369
2007	15.2 %	1.4 %	7,939	52,142
2005	13.1 %	1.0 %	6,843	52,303

Legends:

🚩 Indicator has an unweighted denominator <100 and is not reportable

⚡ Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	11.1 %	2.0 %	13,974	126,050
2017_2018	11.5 %	2.0 %	13,825	119,800
2016_2017	13.9 %	1.9 %	16,615	119,950
2016	11.0 %	1.9 %	12,738	115,773

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None


Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	2.8 %	0.4 %	8,330	299,909
2018	2.9 %	0.6 %	8,796	302,389
2017	2.1 %	0.4 %	6,519	304,896
2016	2.1 %	0.4 %	6,484	306,799
2015	1.4 %	0.3 %	4,350	312,071
2014	2.0 %	0.3 %	6,246	307,392
2013	3.2 %	0.6 %	9,896	306,669
2012	2.9 %	0.5 %	8,844	301,575
2011	3.9 %	0.6 %	11,813	304,365
2010	3.7 %	0.6 %	11,134	302,473
2009	2.6 %	0.5 %	7,498	288,177

Legends: Indicator has an unweighted denominator <30 and is not reportable Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution**NOM 21 - Notes:**

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	73.9 %	3.6 %	14,000	19,000
2015	71.8 %	3.6 %	13,000	18,000
2014	68.4 %	3.7 %	13,000	18,000
2013	69.9 %	3.8 %	13,000	18,000
2012	72.4 %	3.4 %	13,000	19,000
2011	66.5 %	4.2 %	12,000	19,000

Legends:

🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

⚡ Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	67.0 %	2.0 %	185,940	277,523
2018_2019	61.8 %	2.1 %	174,145	281,651
2017_2018	61.0 %	2.4 %	173,982	285,051
2016_2017	60.6 %	2.2 %	169,771	280,243
2015_2016	71.8 %	2.0 %	198,006	275,967
2014_2015	74.4 %	1.9 %	206,844	278,016
2013_2014	70.4 %	2.6 %	194,717	276,586
2012_2013	69.7 %	3.3 %	199,548	286,207
2011_2012	66.6 %	4.0 %	178,392	267,854
2010_2011	70.0 % ⚡	6.4 % ⚡	181,808 ⚡	259,726 ⚡
2009_2010	67.3 %	2.4 %	184,988	274,870

Legends:

🚫 Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	79.4 %	2.9 %	62,610	78,849
2018	76.7 %	2.8 %	60,275	78,556
2017	69.4 %	3.1 %	55,143	79,470
2016	64.8 %	3.2 %	51,921	80,076
2015	66.8 %	2.9 %	52,911	79,172

Legends:

🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

⚡ Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable



NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine**Data Source: National Immunization Survey (NIS) - Teen****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	83.4 %	2.8 %	65,743	78,849
2018	85.8 %	2.3 %	67,412	78,556
2017	84.8 %	2.5 %	67,418	79,470
2016	82.2 %	2.6 %	65,799	80,076
2015	79.6 %	2.5 %	63,034	79,172
2014	82.3 %	2.5 %	66,040	80,260
2013	80.2 %	2.7 %	64,200	80,038
2012	74.1 %	3.0 %	61,021	82,379
2011	67.7 %	3.2 %	56,199	83,036
2010	58.1 %	3.2 %	47,269	81,309
2009	46.1 %	3.5 %	36,222	78,650

Legends: Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2 Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable**NOM 22.4 - Notes:**

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	82.5 %	2.8 %	65,035	78,849
2018	83.6 %	2.5 %	65,643	78,556
2017	85.9 %	2.4 %	68,294	79,470
2016	75.9 %	2.9 %	60,738	80,076
2015	78.7 %	2.5 %	62,278	79,172
2014	77.7 %	2.7 %	62,358	80,260
2013	75.0 %	3.1 %	60,003	80,038
2012	70.4 %	3.2 %	58,019	82,379
2011	70.2 %	3.0 %	58,282	83,036
2010	64.5 %	3.0 %	52,417	81,309
2009	51.0 %	3.5 %	40,094	78,650

Legends:

🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

⚡ Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None


Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	15.7	0.7	584	37,302
2018	17.2	0.7	643	37,345
2017	19.1	0.7	714	37,287
2016	19.2	0.7	728	37,877
2015	20.7	0.7	789	38,123
2014	23.2	0.8	893	38,413
2013	25.0	0.8	976	39,000
2012	27.9	0.8	1,108	39,717
2011	29.7	0.9	1,199	40,367
2010	32.6	0.9	1,347	41,288
2009	37.0	0.9	1,547	41,755


Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 23 - Notes:**

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	11.1 %	1.8 %	915	8,236
2015	9.0 %	1.1 %	1,610	17,938
2014	11.0 %	1.2 %	1,974	17,970
2013	9.5 %	1.0 %	1,748	18,407
2012	10.6 %	1.0 %	1,938	18,254

Legends: Indicator has an unweighted denominator <30 and is not reportable Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution**NOM 24 - Notes:**

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	1.6 % ⚡	0.5 % ⚡	4,803 ⚡	300,123 ⚡
2017_2018	1.6 % ⚡	0.5 % ⚡	4,864 ⚡	301,799 ⚡
2016_2017	1.7 %	0.5 %	5,239	305,190
2016	2.7 %	0.8 %	8,400	307,347

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)
State: Hawaii

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	2017	2018	2019	2020
Annual Objective					77
Annual Indicator				76.6	78.1
Numerator				184,106	185,323
Denominator				240,287	237,398
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

i Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	79.0	81.0	83.0	85.0	87.0	89.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2021
	Column Name:	Annual Objective

Field Note:

Based on the growth pattern demonstrated in the 2018-2019 data and consultation with program staff, the state objectives from 2021 to 2026 reflects an annual increase of 2 percentage points.

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	2017	2018	2019	2020
Annual Objective	79	79	80	82	82
Annual Indicator	79.2	81.5	81.5	81.5	84.0
Numerator	14,243	14,376	14,376	14,376	6,895
Denominator	17,975	17,634	17,634	17,634	8,212
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2015	2015	2019

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	85.0	86.0	87.0	87.0	88.0	89.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2021
	Column Name:	Annual Objective

Field Note:

The state objectives through 2026 reflect an approximate 5% improvement over 5 years.

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2020
Annual Objective	21
Annual Indicator	28.7
Numerator	2,245
Denominator	7,829
Data Source	PRAMS
Data Source Year	2019

State Provided Data				
	2017	2018	2019	2020
Annual Objective			1	21
Annual Indicator	100	100	20.3	28.7
Numerator	1	1	3,306	2,245
Denominator	1	1	16,296	7,829
Data Source	1	1	PRAMS	PRAMS
Data Source Year	1	1	2016	2019
Provisional or Final ?	Provisional	Provisional	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	29.0	30.0	30.0	31.0	31.0	32.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	1 is entered because PRAMS 2016 data is not available in State
2.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	1 is entered because PRAMS 2017 data is not available in State
3.	Field Name:	2019
	Column Name:	State Provided Data
	Field Note:	There was no PRAMS data collection in Hawaii from 2017 to 2018, and no data on this measure prior to 2016. This is the first year data was provided on this measure.
4.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note:	Based on 2019 PRAMS, which is same as FAD this year.
5.	Field Name:	2021
	Column Name:	Annual Objective
	Field Note:	The state objectives through 2026 reflect an approximate 5% improvement over 5 years.

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2020
Annual Objective	33
Annual Indicator	48.1
Numerator	3,755
Denominator	7,801
Data Source	PRAMS
Data Source Year	2019

State Provided Data				
	2017	2018	2019	2020
Annual Objective			1	33
Annual Indicator	100	100	46.2	48.1
Numerator	1	1	5,186	3,755
Denominator	1	1	11,228	7,801
Data Source	1	1	PRAMS	PRAMS
Data Source Year	1	1	2016	2019
Provisional or Final ?	Provisional	Provisional	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	49.0	49.0	50.0	50.0	51.0	51.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	1 is entered because PRAMS 2016 data is not available in State
2.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	1 is entered because PRAMS 2017 data is not available in State
3.	Field Name:	2019
	Column Name:	State Provided Data
	Field Note:	There was no PRAMS data collection in Hawaii from 2017 to 2018, and no data on this measure prior to 2016. This is the first year data was provided on this measure.
4.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note:	Based on 2019 PRAMS, which is same as FAD this year.
5.	Field Name:	2021
	Column Name:	Annual Objective
	Field Note:	The state objectives through 2026 reflect an approximate 5% improvement over 5 years.

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	2017	2018	2019	2020
Annual Objective			33	39	40
Annual Indicator		32.0	39.1	36.5	31.6
Numerator		12,946	14,121	13,201	12,899
Denominator		40,486	36,113	36,145	40,832
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	40.0	41.0	41.0	42.0	42.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2021
	Column Name:	Annual Objective
	Field Note:	The state objectives through 2026 reflect an approximate 5% improvement over 5 years.

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	2017	2018	2019	2020
Annual Objective			74	75	77
Annual Indicator		73.5	74.6	74.6	77.7
Numerator		67,325	74,226	74,226	76,702
Denominator		91,592	99,470	99,470	98,664
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	81.0	82.0	84.0	86.0	87.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2021
	Column Name:	Annual Objective

Field Note:

The annual performance objective for years 2021-2026 reflects an approximate 10% improvement over 5 years distributed among the individual years.

NPM 12 - 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 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	2017	2018	2019	2020
Annual Objective			23	23	25
Annual Indicator		23.3	21.9	24.7	17.1
Numerator		4,235	4,457	5,037	3,214
Denominator		18,144	20,375	20,412	18,758
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	26.0	26.0	27.0	27.0	28.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2021
	Column Name:	Annual Objective
	Field Note:	The state objectives through 2026 reflect an approximate 10% improvement over 5 years.

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Hawaii

2016-2020: NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	2017	2018	2019	2020
Annual Objective	90	91	89	91	92
Annual Indicator	90.6	87.3	90.6	88.9	89.1
Numerator	15,214	15,007	15,313	15,129	13,103
Denominator	16,789	17,199	16,911	17,014	14,711
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 4B - Percent of infants breastfed exclusively through 6 months


Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	2017	2018	2019	2020
Annual Objective	27	30	30	33	34
Annual Indicator	30.1	30.2	32.9	33.2	30.6
Numerator	4,828	5,029	5,396	5,473	4,256
Denominator	16,071	16,662	16,415	16,511	13,927
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	2017	2018	2019	2020
Annual Objective			84	85	86
Annual Indicator		83.1	84.9	85.6	85.5
Numerator		243,681	242,790	234,467	239,545
Denominator		293,312	285,950	273,914	280,315
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

 Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Hawaii

SPM 1 - Rate of confirmed child abuse and neglect reports per 1,000 for children ages 0 to 5 years.

Measure Status:			Active	
State Provided Data				
	2017	2018	2019	2020
Annual Objective			5.9	5.5
Annual Indicator		5.9	5.5	5.7
Numerator		635	584	591
Denominator		108,119	105,815	104,141
Data Source		DHS CAN annual report	DHS CAN annual report	DHS CAN annual report
Data Source Year		2017	2018	2019
Provisional or Final ?		Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.4	5.4	5.3	5.3	5.2	5.2

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note: Data from 2017 DHS CAN annual report (http://humanservices.hawaii.gov/reports/child-abuse-and-neglect-reports/) represents a rate of 5.9 per 1,000 children 0-5 years of age (Numerator: 635 unique children confirmed victims; Denominator: 2017 Census Estimate 0-5 years: 108,119).	
2.	Field Name:	2019
	Column Name:	State Provided Data
	Field Note: Baseline Data from 2019 DHS CAN annual report (http://humanservices.hawaii.gov/reports/child-abuse-and-neglect-reports/) represents a rate of 5.7 per 1,000 children 0-5 years of age (Numerator: 591 unique children confirmed victims; Denominator: 2019 Census Estimate 0-5 years: 104,141).	
3.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note: Baseline Data from 2019 DHS CAN annual report (http://humanservices.hawaii.gov/reports/child-abuse-and-neglect-reports/) represents a rate of 5.7 per 1,000 children 0-5 years of age (Numerator: 591 unique children confirmed victims; Denominator: 2019 Census Estimate 0-5 years: 104,141).	
4.	Field Name:	2021
	Column Name:	Annual Objective
	Field Note: Objectives for 2021-2026 were set at 5% improvement over 5 years spread out over individual years.	

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) services

Measure Status:		Active
State Provided Data		
	2020	
Annual Objective		
Annual Indicator	25,584	
Numerator		
Denominator		
Data Source	Hawaii WIC Services	
Data Source Year	2020	
Provisional or Final ?	Final	

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	27,000.0	28,000.0	29,000.0	30,000.0	31,000.0

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note:	Indicator is number of WIC enrollments for 2020
2.	Field Name:	2022
	Column Name:	Annual Objective
	Field Note:	The state objectives through 2026 reflect an increase of 1,000 per year.

SPM 3 - The number of pediatric and/or behavioral health providers receiving training and support services on pediatric mental health care in underserved communities/counties statewide.

Measure Status:		Active
State Provided Data		
	2020	
Annual Objective		
Annual Indicator	0	
Numerator		
Denominator		
Data Source	Hawaii Pediatric Mental Health Care Access grant	
Data Source Year	2020	
Provisional or Final ?	Final	

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	20.0	40.0	60.0	80.0	100.0

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note: The number of pediatric/mental health providers trained on Pediatric Mental Health Care is 0 for 2020.	
2.	Field Name:	2022
	Column Name:	Annual Objective
	Field Note: Objectives are set by program staff, with an improvement of 20 per year.	

SPM 4 - Number of new telehealth access points established with health and digital navigators in public libraries located in underserved communities statewide

Measure Status:		Active
State Provided Data		
	2020	
Annual Objective		
Annual Indicator	0	
Numerator		
Denominator		
Data Source	Hawaii Title V Genetics Program	
Data Source Year	2020	
Provisional or Final ?	Final	

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	9.0	15.0	15.0	15.0	15.0

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note: This is a new measure. The number of telehealth access point in 2020 is 0.	
2.	Field Name:	2022
	Column Name:	Annual Objective
	Field Note: Based on consultation with program staff, the objective is to establish 15 new telehealth access points with health and digital navigators in public libraries located in underserved communities statewide by July 2023.	

SPM 5 - The percentage of Medicaid children receiving six or more well-child visits in the first 15 months of life

Measure Status:		Active
State Provided Data		
	2020	
Annual Objective		
Annual Indicator	72	
Numerator		
Denominator		
Data Source	Hawaii Med-QUEST	
Data Source Year	2019	
Provisional or Final ?	Final	

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	81.0	84.0	87.0	90.0	93.0

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note:	Only annual indicator is available. Numerator and denominator are not available for this measure.
2.	Field Name:	2022
	Column Name:	Annual Objective
	Field Note:	Based on discussion with program staff, the objectives for 2021-2026 will be an increase of 3% per year. Our 2020 objective will be 75%, and 2021 objective, 78%.

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers.

Measure Status:				Active	
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			11	13	14
Annual Indicator					
Numerator	8	11	28	42	72
Denominator	72	72	72	72	72
Data Source	Telehealth work group, Family Health Services Divi	The preliminary 5-year plan objectives were develo	Telehealth work group, FHSD	Telehealth work group, FHSD	Telehealth work group, FHSD
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	The measure is a scale. Converting into percentages the annual indicator would be $8/72 = 11.1\%$
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	The measure is a scale. Converting into percentages the annual indicator would be $11/72 = 15.3\%$
3.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	The measure is a scale. Converting into percentages the annual indicator would be $12/72 = 16.7\%$
4.	Field Name:	2019
	Column Name:	State Provided Data
	Field Note:	The measure is a scale. Converting into percentages the annual indicator would be $42/72 = 58.3\%$
5.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note:	The measure is a scale. Converting into percentages the annual indicator would be $72/72 = 100\%$

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Hawaii

ESM 1.1 - Percent of births with less than 18 months spacing between birth and next conception

Measure Status:					Active
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		34	31	31	31
Annual Indicator	32.7	31.7	31.9	30.9	32.4
Numerator	3,013	2,849	2,773	2,661	2,558
Denominator	9,225	8,974	8,693	8,599	7,903
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	31.0	31.0	31.0	30.0	30.0	30.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	Estimate for 2016 based on final data
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	Estimate based on 2017 final vital statistics data file
3.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	Estimate based on 2018 final vital statistics data
4.	Field Name:	2019
	Column Name:	State Provided Data
	Field Note:	Estimate based on 2019 provisional vital statistics data file as final 2019 data file not available
5.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note:	Estimate based on 2020 provisional vital statistics data file as final 2020 data file not available
6.	Field Name:	2021
	Column Name:	Annual Objective
	Field Note:	Objectives for 2021-2026 were set for 5% improvement over 5 years.

ESM 5.1 - The number of languages in which safe sleep educational materials are available for Hawaii's communities.

Measure Status:			Active
State Provided Data			
	2018	2019	2020
Annual Objective			11
Annual Indicator			0
Numerator			
Denominator			
Data Source			Hawaii Safe Sleep Program
Data Source Year			2020
Provisional or Final ?			Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	11.0	11.0	11.0	11.0	11.0	11.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2020
	Column Name:	State Provided Data

Field Note:

The strategy to translate safe sleep educational and general awareness messages to languages for non-English speaking populations remains and SSH works to distribute the information to agencies and community programs serving families with infants. Distribution of the materials have been hampered somewhat by COVID-19. With the safe sleep guide primarily being distributed as a hard copy, SSH and DOH are working on providing electronic copies. Plans are being made for website and possibly social media for dissemination.

ESM 6.1 - 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

Measure Status:			Active	
State Provided Data				
	2017	2018	2019	2020
Annual Objective			12	18
Annual Indicator				
Numerator	9	19	23	26
Denominator	30	30	30	30
Data Source	Early Childhood Coordinator	Early Childhood Coordinator	Early Childhood Coordinator	Early Childhood Coordinator
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	24.0	27.0	30.0	30.0	30.0	30.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	The measure is a scale and the annual indicator for 2017 is 9. Converting to percentage $9/30 = 30.0\%$
2.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	The measure is a scale and the annual indicator for 2018 is 19. Converting to percentage $19/30 = 63.3\%$
3.	Field Name:	2019
	Column Name:	State Provided Data
	Field Note:	The measure is a scale and the annual indicator for 2019 is 23. Converting to percentage $23/30 = 76.7\%$

4.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note:	The measure is a scale and the annual indicator for 2020 is 26. Converting to percentage $26/30 = 86.7\%$
5.	Field Name:	2021
	Column Name:	Annual Objective
	Field Note:	The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2021 objective will be $24/30 = 80.0\%$.
6.	Field Name:	2022
	Column Name:	Annual Objective
	Field Note:	The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2022 objective will be $27/30 = 90.0\%$.
7.	Field Name:	2023
	Column Name:	Annual Objective
	Field Note:	The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2023 objective will be $30/30 = 100.0\%$.
8.	Field Name:	2024
	Column Name:	Annual Objective
	Field Note:	The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2024 objective will be $30/30 = 100.0\%$.
9.	Field Name:	2025
	Column Name:	Annual Objective
	Field Note:	The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2025 objective will be $30/30 = 100.0\%$.
10.	Field Name:	2026
	Column Name:	Annual Objective
	Field Note:	The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2026 objective will be $30/30 = 100.0\%$.

ESM 10.1 - Develop and disseminate a teen-centered, Adolescent Resource Toolkit (ART) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits

Measure Status:		Active	
State Provided Data			
	2018	2019	2020
Annual Objective			18
Annual Indicator			
Numerator	9	13	18
Denominator	30	30	30
Data Source	ART and Science Workgroup	ART and Science Workgroup	ART and Science Workgroup
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	23.0	25.0	28.0	30.0	30.0	30.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	Converting to percentage $9/30 = 30.0\%$
2.	Field Name:	2019
	Column Name:	State Provided Data
	Field Note:	Converting to percentage $13/30 = 43.3\%$
3.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note:	Converting to percentage $18/30 = 60.0\%$

4.	Field Name:	2021
	Column Name:	Annual Objective
	Field Note: The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2021 objective will be $23/30 = 76.7\%$.	
5.	Field Name:	2022
	Column Name:	Annual Objective
	Field Note: The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2022 objective will be $25/30 = 83.3\%$.	
6.	Field Name:	2023
	Column Name:	Annual Objective
	Field Note: The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2023 objective will be $28/30 = 93.3\%$.	
7.	Field Name:	2024
	Column Name:	Annual Objective
	Field Note: The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2024 objective will be $30/30 = 100\%$.	
8.	Field Name:	2025
	Column Name:	Annual Objective
	Field Note: The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2025 objective will be $30/30 = 100\%$.	
9.	Field Name:	2026
	Column Name:	Annual Objective
	Field Note: The objectives for this program are set by program staff. The measure is scale where the denominator is 30. Converting into percentage, the 2026 objective will be $30/30 = 100\%$.	

ESM 12.1 - 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.

Measure Status:					Active
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			17	21	24
Annual Indicator					
Numerator	12	13	18	22	27
Denominator	33	33	33	33	33
Data Source	Title V Transition Workgroup	Title V Transition Workgroup	Title V Transition Workgroup	Title V Transition Workgroup	Title V Transition Workgroup
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	26.0	28.0	30.0	33.0	33.0	33.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	The measure is a scale and the annual indicator for 2017 is 13. Converting into percentage $13/33 = 39.4\%$
2.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	The measure is a scale and the annual indicator for 2018 is 18. Converting into percentage $18/33 = 54.5\%$
3.	Field Name:	2019
	Column Name:	State Provided Data

	Field Note: The measure is a scale and the annual indicator for 2019 is 22. Converting into percentage $22/33 = 66.7\%$
4.	Field Name: 2020
	Column Name: State Provided Data
	Field Note: The measure is a scale and the annual indicator for 2020 is 26.5. Converting into percentage $26.5/33 = 80.3\%$
5.	Field Name: 2021
	Column Name: Annual Objective
	Field Note: The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2021 objective will be $26/33 = 78.8\%$.
6.	Field Name: 2022
	Column Name: Annual Objective
	Field Note: The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2022 objective will be $28/33 = 84.8\%$.
7.	Field Name: 2023
	Column Name: Annual Objective
	Field Note: The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2023 objective will be $30/33 = 90.9\%$.
8.	Field Name: 2024
	Column Name: Annual Objective
	Field Note: The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2024 objective will be $33/33 = 100\%$.
9.	Field Name: 2025
	Column Name: Annual Objective
	Field Note: The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2025 objective will be $33/33 = 100\%$.
10.	Field Name: 2026
	Column Name: Annual Objective

Field Note:

The objectives for this program are set by program staff. The measure is scale where the denominator is 33. Converting into percentage, the 2026 objective will be $33/33 = 100\%$.

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 4.1 - Percent of Women, Infants, and Children (WIC) infants ever breastfed

Measure Status:				Active	
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		81	81	82	83
Annual Indicator	80.6	80.6	80.6	80.6	80.6
Numerator	12,996	12,996	12,996	12,996	12,996
Denominator	16,132	16,132	16,132	16,132	16,132
Data Source	HI WIC Services Program	HI WIC Services Program	HI WIC Services Program	HI WIC Services Program	HI WIC Services Program
Data Source Year	2016	2016	2016	2016	2016
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note: The number is obtained for SFY 2016 (July 1, 2015 to June 30, 2016). Numerator: Unduplicated number of WIC infants by SFY 2016 Denominator: Unduplicated number of WIC infants ever breastfed by SFY 2016	
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note: Due to changes in data collection system over the transition completed in May 2017, no comparable data was available to report with this ESM so the 2016 data was carried over to 2017.	
3.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note: Due to changes in data collection system over the transition completed in May 2017, no comparable data was available to report with this ESM so the 2016 data was carried over to 2018.	
4.	Field Name:	2019
	Column Name:	State Provided Data
	Field Note: Due to changes in data collection system over the transition completed in May 2017, no comparable data was available to report with this ESM so the 2016 data was carried over to 2019.	
5.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note: Due to changes in data collection system over the transition completed in May 2017, no comparable data was available to report with this ESM so the 2016 data was carried over to 2020.	

2016-2020: ESM 13.2.3 - The number of organizations and individuals participating in State Oral Health Coalition meetings and activities

Measure Status:		Active	
State Provided Data			
	2018	2019	2020
Annual Objective			60
Annual Indicator	48	64	64
Numerator			
Denominator			
Data Source	Hawaii Oral Health Coalition	Hawaii Oral Health Coalition	Hawaii Oral Health Coalition
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: Hawaii

SPM 1 - Rate of confirmed child abuse and neglect reports per 1,000 for children ages 0 to 5 years.

Population Domain(s) – Child Health

Measure Status:	Active	
Goal:	Reduce the rate of child abuse and neglect with special attention on ages 0-5 years.	
Definition:	Unit Type:	Rate
	Unit Number:	1,000
	Numerator:	Number of confirmed Child Protective Services reports of abuse and neglect for children aged 0 to 5 years
	Denominator:	Number of children aged 0 to 5 years in the state based on decennial census (2010 data reported 104,333 children)
Data Sources and Data Issues:	Hawaii Department of Human Services, Management Services Office. Child Abuse and Neglect Annual reports	
Significance:	Child abuse and neglect has pervasive effects over a person's lifetime. Abuse has negative effects not only on physical health but also on mental, emotional and social health of individuals.	

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) services
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active	
Goal:	Reduce the rate food insecurity for pregnant women and infants through the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) services	
Definition:	Unit Type:	Count
	Unit Number:	50,000
	Numerator:	Number of WIC enrollments
	Denominator:	
Data Sources and Data Issues:	Hawaii WIC Services	
Significance:	<p>It has long been recognized that children living in poverty lag behind other children on a wide range of indicators of physical, mental, academic, and economic well-being. They are more likely to have health, behavioral, learning, and emotional problems. This is especially true of children whose families experience deep poverty, those who are poor during early childhood, and those who are poor for a long time. Children living in poverty are also more likely to be food insecure, and food insecurity in households with children is associated with inadequate intake of several important nutrients, deficits in cognitive development, behavioral problems, and poor health.</p> <p>Over more than four decades, researchers have investigated WIC’s effects on key measures of child health such as birth weight, infant mortality, diet quality and nutrient intake, initiation and duration of breastfeeding, cognitive development and learning, immunization, use of health services, and childhood anemia. Taken as a whole, the evidence demonstrates WIC’s effectiveness.</p>	

SPM 3 - The number of pediatric and/or behavioral health providers receiving training and support services on pediatric mental health care in underserved communities/counties statewide.

Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active	
Goal:	Address health equity and disparities by addressing children's mental health and services in rural and under-served communities.	
Definition:	Unit Type:	Count
	Unit Number:	300
	Numerator:	Number pediatric/mental health providers trained on Pediatric Mental Health Care.
	Denominator:	
Healthy People 2030 Objective:	Increase the proportion of children with mental health problems who get treatment (MHMD-03).	
	Increase the proportion of children and adolescents who get appropriate treatment for behavior problems (EMC-D05).	
Data Sources and Data Issues:	Hawaii Pediatric Mental Health Care Access grant.	
Significance:	The COVID pandemic highlighted the mental health needs of children and primary care and mental health provider shortages. The MCH Evidence Center has ample evidence to show telehealth services can improve access to healthcare to underserved MCH populations.	

SPM 4 - Number of new telehealth access points established with health and digital navigators in public libraries located in underserved communities statewide

Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active	
Goal:	Address health and digital inequity experienced by underserved families by expanding access to telehealth services at public library location.	
Definition:	Unit Type:	Count
	Unit Number:	50
	Numerator:	Number of telehealth access points established in state public libraries
	Denominator:	
Healthy People 2030 Objective:	Related to AHS R02: Increase the use of telehealth to improve access to health services (research objective only)	
Data Sources and Data Issues:	Hawaii Title V Genetics Program	
Significance:	The COVID pandemic highlighted the health and digital inequity experienced by many underserved families. Some families do not have the digital literacy to access information and services on-line or do not have devices and/or adequate internet or cellular service even if they know how to use the internet. The MCH Evidence Center has ample evidence to show telehealth services can improve access to healthcare to underserved MCH populations.	

SPM 5 - The percentage of Medicaid children receiving six or more well-child visits in the first 15 months of life
Population Domain(s) – Child Health

Measure Status:	Active	
Goal:	Address health equity and disparities by assuring low-income children on Medicaid are receiving well-child visits.	
Definition:	Unit Type:	Percentage
	Unit Number:	100
	Numerator:	Number of Medicaid children receiving six or more well-child visits in the first 15 months of life
	Denominator:	Total number of Medicaid children 0-15 months eligible for Medicaid services.
Healthy People 2030 Objective:	HP 2030 objective: Reduce the proportion of children who get no recommended vaccines by age 2 years — IID-02	
Data Sources and Data Issues:	CMS Medicaid & CHIP Scorecard, Medicaid & CHIP I Hawaii. Hawaii Medicaid.gov The rate includes managed care population (from 5 managed care organizations). The rate was derived using both administrative and hybrid method data. One MCO used the administrative method and four MCOs used the hybrid method. Denominator is the measure-eligible population. Rate was validated by the state's External Quality Review Organization (EQRO). Hawaii is working with the state Medicaid office to identify the best Medicaid measure for this priority.	
Significance:	The American Academy of Pediatrics and Bright Futures recommend nine well-care visits by the time children turn 15 months of age. These visits should include a health history, physical examination, immunizations, vision and hearing screening, developmental/behavioral assessment, and oral health assessment, as well as parenting education on a wide range of topics. This is part of the 2019 Medicaid Child Core Set of Quality of Care Measures. The COVID pandemic may have resulted in delays/postponement of these visits as reported by the Centers for Disease Control and preliminary data from the Centers for Medicare & Medicaid Services (CMS).	

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - The degree to which Title V programs utilize telehealth to improve access to services and education for families and providers.

Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active								
Goal:	Increase the use of telehealth across Title V activities to improve access to services and education for families and providers.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td><td>Scale</td></tr> <tr> <td>Unit Number:</td><td>72</td></tr> <tr> <td>Numerator:</td><td>Total Actual Scores from three Telehealth Data Collection Forms</td></tr> <tr> <td>Denominator:</td><td>Total Possible Scores from three Telehealth Data Collection Forms (18, 24, 30)</td></tr> </table>	Unit Type:	Scale	Unit Number:	72	Numerator:	Total Actual Scores from three Telehealth Data Collection Forms	Denominator:	Total Possible Scores from three Telehealth Data Collection Forms (18, 24, 30)
Unit Type:	Scale								
Unit Number:	72								
Numerator:	Total Actual Scores from three Telehealth Data Collection Forms								
Denominator:	Total Possible Scores from three Telehealth Data Collection Forms (18, 24, 30)								
Healthy People 2020 Objective:	HP2020 Health Communication & Health Information Technology Goal: Use health communication strategies and health information technology (IT) to improve population health outcomes and health care quality, and to achieve health equity.								
Data Sources and Data Issues:	<p>This is a summary of the Data Collection Form that lists 24 strategy components organized by the three areas in telehealth activities:</p> <ul style="list-style-type: none"> • Infrastructure development • Training/education development • Service development <p>Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 72. Scoring is completed by FHSD staff. The data collection form is attached as a supporting document.</p>								
Significance:	With the reduction in personnel resources, increases in travel costs, and availability of high speed internet and affordable devices, telehealth can be one of the tools to increase access to families and providers while saving costs and travel time. Telehealth can be used to increase access to services for families, care coordination activities, education for providers, and workforce training for public health staff.								

Form 10
State Outcome Measure (SOM) Detail Sheets
State: Hawaii

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Hawaii

ESM 1.1 - Percent of births with less than 18 months spacing between birth and next conception

NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active								
Goal:	To support reproductive life planning and healthy birth outcomes by increasing intervals of birth spacing (births spaced from 18 month to next conception).								
Definition:	<table border="1"> <tr> <td>Unit Type:</td><td>Percentage</td></tr> <tr> <td>Unit Number:</td><td>100</td></tr> <tr> <td>Numerator:</td><td>Number of Births with interval < 18 months between birth and next conception</td></tr> <tr> <td>Denominator:</td><td>Total number of Births</td></tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of Births with interval < 18 months between birth and next conception	Denominator:	Total number of Births
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Number of Births with interval < 18 months between birth and next conception								
Denominator:	Total number of Births								
Data Sources and Data Issues:	<p>Data source is vital statistics, Office of Health Status Monitoring.</p> <p>Calculation of interval is based on birth certificate data with valid clinical estimate of gestational age of index birth and prior live birth.</p> <p>Pregnancy Interval = ConceptionDate – Last Live Birth (following HRSA ColIN to reduce infant mortality outcome measure).</p>								
Significance:	<p>Research shows that effective contraception can help with birth spacing, reduce the risk of low-weight and premature births, and support a woman's longer term physical and emotional well-being. The Centers for Disease Control and Prevention has identified Long Acting Reversible Contraception (LARC) as among the most effective family planning methods with a pregnancy rate of less than 1 pregnancy per 100 women in the first year. LARC's intrauterine devices (IUDs) and contraceptive implants are highly effective methods of birth control and can last between 3 and 10 years (depending on the method). Incorporating pregnancy intention screenings in routine and proactive settings where reproductive health age women are likely to be screened every 3 months to a year, regardless of the reason for a women's visit supports the use of One Key Question®(OKQ) and multiple opportunities for these interventions with discussions that can lead to opportunities for preconception care and contraceptive services. References: Department of Health and Human Services, Centers for Medicaid and Medicare Services, CMCS Informational Bulletin, April 8, 2016, State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception; Augustin Conde Aguelo, MD, MPH; Anyeli Rosas-Bermudez, MPH; Ana Cecilia Kafury-Goeta, MD (2006). Birth Spacing and Risk of Adverse Perinatal Outcomes: A Meta-analysis. JAMA 295 (15): 1809-1823. Trussell J. Contraceptive efficacy. In: Hatcher R, Trussell J, Nelson A, Cates W, Kowal D, Policar M, eds. Contraceptive Technology. 20th ed. New York, NY: Ardent Media; 2011:779-863. Oregon Foundation for Reproductive Health One Key Question®.</p>								

ESM 5.1 - The number of languages in which safe sleep educational materials are available for Hawaii's communities.


NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active	
Goal:	Expand outreach to Non-English-speaking families and care givers through translation of educational and general awareness safe sleep messages.	
Definition:	Unit Type:	Count
	Unit Number:	20
	Numerator:	Number of languages Departments of Health (DOH) & Human Services (DHS) safe sleep are available for Hawaii’s communities
	Denominator:	
Data Sources and Data Issues:	Data will be collected by Safe Sleep Hawaii about the efforts by DOH, DHS and the State Office of Language Access to translate educational materials into other languages for use by non-English speakers.	
Significance:	About 3,500 US infants die suddenly and unexpectedly each year. These deaths are referred to as sudden unexpected infant deaths (SUID). SUID is one of the three leading-causes of death among infants nationally and in Hawaii (Hayes DK, Calhoun CR, Byers TJ, Chock LR, Heu PL, Tomiyasu DW, Sakamoto DT, and Fuddy LJ. Saving Babies: Reducing Infant Mortality in Hawaii. Hawaii Journal of Medicine and Public Health. 2013. 72 (2): 246-251).	
	The American Academy of Pediatrics (AAP) recommends a safe sleep environment to reduce the risk of all sleep-related infant deaths. AAP recommendations for a safe sleep environment include supine positioning, the use of a firm sleep surface, room-sharing without bed-sharing, and the avoidance of soft bedding and overheating. Additional recommendations for SUID reduction include the avoidance of exposure to smoke, alcohol, and illicit drugs; breastfeeding; routine immunization; and use of a pacifier.	
	The AAP recommends education should include all who care for infants, including parents, child care providers, grandparents, foster parents, and babysitters, and should include strategies for overcoming barriers to behavior change.	
	Research on health education and SUID outreach has found that response to safe sleep messages differed among different communities and racial/ethnic groups, which may help explain some of the lingering differences in SUID rates. Therefore, campaigns should have a special focus on getting safe sleep messages to parents and caregivers in diverse communities because of the higher incidence of SUID and other sleep-related infant deaths in these groups.	

ESM 6.1 - 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

NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active								
Goal:	Increase the number of children receiving developmental screening and referred and receiving services among Hawaii Title V direct service programs.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td><td>Scale</td></tr> <tr> <td>Unit Number:</td><td>30</td></tr> <tr> <td>Numerator:</td><td>Total scale score based on program assessment of 10 steps</td></tr> <tr> <td>Denominator:</td><td>30</td></tr> </table>	Unit Type:	Scale	Unit Number:	30	Numerator:	Total scale score based on program assessment of 10 steps	Denominator:	30
Unit Type:	Scale								
Unit Number:	30								
Numerator:	Total scale score based on program assessment of 10 steps								
Denominator:	30								
Data Sources and Data Issues:	Program Data. The ESM 6.2 is using the Hawaii Title V Developmental Screening Workgroup's Policy and Public Health Coordination (PPHC) rating scale to monitor infrastructure development on developmental screening and services within FHSD. It will be a self-assessment of the team's efforts to improve efforts to develop the infrastructure for FHSD screening and services and will be measured annually.								
Significance:	<p>The PPHC will help measure Hawaii's efforts to improve the service delivery and systems development for developmental screening with the end goal of all the strategies and activities completion will signify that the system has been developed. A Policy and Public Health Coordination Scale (PPHCS) has been created to monitor/track progress made on the 5-Year plan strategies for developmental screening. The Title V Screening Workgroup will complete the scale annually starting in FFY 2019 as part of routine evaluation. Element 0 --Not met 1--Partially Met 2--Mostly Met 3--Completely Met</p> <p>Systems Development</p> <ol style="list-style-type: none"> 1. Develop guidelines and toolkit for screening, referral and services. 2. Work with partners to develop infrastructure for ongoing training, technical assistance, and support for providers conducting developmental screening activities. <p>Family Engagement and Public Awareness</p> <ol style="list-style-type: none"> 3. Work with families and parent organizations to develop family-friendly material explaining importance of developmental screening and how to access services. 4. Develop website to house materials, information and resources on developmental screening. <p>Data Collection and Integration</p> <ol style="list-style-type: none"> 5. Develop data system for internal tracking and monitoring of screening, referral, and services data. 6. Develop process for on-going communication to review data findings and make adjustments for better outcomes for children and families <p>Policy and Public Health Coordination</p> <ol style="list-style-type: none"> 7. Develop Policy and Public Health Coordination Scale. 8. Conduct process for annual assessment of rating scale. 								



Social Determinants of Health and Vulnerable Populations

9. Develop process for identifying vulnerable populations.

10. Work with stakeholders to address supports and targeted interventions for vulnerable populations

ESM 10.1 - Develop and disseminate a teen-centered, Adolescent Resource Toolkit (ART) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active								
Goal:	Increase resources, training and practice improvement support for adolescent health and service providers to promote wellness and healthcare visits aligned to Bright Futures.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td><td>Scale</td></tr> <tr> <td>Unit Number:</td><td>30</td></tr> <tr> <td>Numerator:</td><td>Total Actual Score from Adolescent Health Data Collection Form</td></tr> <tr> <td>Denominator:</td><td>Total Possible Score from Adolescent Health Data Collection Form (30 total)</td></tr> </table>	Unit Type:	Scale	Unit Number:	30	Numerator:	Total Actual Score from Adolescent Health Data Collection Form	Denominator:	Total Possible Score from Adolescent Health Data Collection Form (30 total)
Unit Type:	Scale								
Unit Number:	30								
Numerator:	Total Actual Score from Adolescent Health Data Collection Form								
Denominator:	Total Possible Score from Adolescent Health Data Collection Form (30 total)								
Data Sources and Data Issues:	<p>This is a summary of the Data Collection Form that lists 10 strategy components organized by the following domains:</p> <ul style="list-style-type: none"> • Collaboration • Engagement to Develop the Adolescent Resource Toolkit • Workforce Development Training for Community Stakeholders <p>Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 30. Scoring is completed by Adolescent Health staff, with input from key partners.</p>								
Significance:	<p>Adolescence is a period of major physical, psychological and social development and the initiation of risky behaviors as teens move from childhood toward adulthood. Teens assume individual responsibility for health habits. An annual preventive well visit may help teens adopt or maintain health habits and behaviors and avoid health damaging behaviors. The Bright Futures guidelines recommend that teens have an annual checkup from age 11-21 years, however many do not. Barriers include:</p> <ul style="list-style-type: none"> • Lack of awareness of guidelines • Perception that the AWC lacks value • Unaware or variability of insurance coverage and follow up services • High utilization of sports physicals instead of AWC • Inconsistent practices addressing confidentiality • Lack of medical home • Lack of knowledge of community resources. <p>The ART and collaboration with community/youth service providers will help to address many of these barriers and build the knowledge base of professionals working with youth.</p>								

ESM 12.1 - 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 12 – 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

Measure Status:	Active									
Goal:	To increase the degree to which the Title V CYSHNS promotes and/or facilitates transition to adult health care for YSHCN.									
Definition:	<table><tr><td>Unit Type:</td><td>Scale</td></tr><tr><td>Unit Number:</td><td>33</td></tr><tr><td>Numerator:</td><td>Total Actual Score from Transition to Adult Health Care Data Collection Form</td></tr><tr><td>Denominator:</td><td>Total Possible Score from Transition to Adult Health Care Data Collection Form (33)</td></tr></table>		Unit Type:	Scale	Unit Number:	33	Numerator:	Total Actual Score from Transition to Adult Health Care Data Collection Form	Denominator:	Total Possible Score from Transition to Adult Health Care Data Collection Form (33)
Unit Type:	Scale									
Unit Number:	33									
Numerator:	Total Actual Score from Transition to Adult Health Care Data Collection Form									
Denominator:	Total Possible Score from Transition to Adult Health Care Data Collection Form (33)									
Data Sources and Data Issues:	<p>This is a summary of the Data Collection Form that lists 11 strategy components organized by the Six Core Elements of Health Care Transition:</p> <ul style="list-style-type: none">• Transition policy• Transition tracking and monitoring• Transition readiness• Transition planning• Transfer of care• Transition completion. <p>Each item is scored from 0-3 (0=not met; 1=partially met; 2=mostly met; 3=completely met), with a maximum total of 33. Scoring is completed by CYSHNS staff, with input from Hilopaa Family to Family Health Information Center. The data collection form is attached as a supporting document.</p>									
Significance:	<p>CYSHNS is addressing Got Transition's Six Core Elements of Health Care Transition 2.0. Strategy components were adapted for integration as part of CYSHNS services to support youth/families in preparing for transition to adult health care.</p> <p>Health and health care are important to making successful transitions. The majority of YSHCN do not receive needed support to transition from pediatric to adult health care. In addition, YSHCN, compared to those without special health care needs, are less likely to complete high school, attend college, or be employed. The Title V CYSHNS has been addressing these barriers through providing general transition information to families receiving CYSHNS /clinic services or attending transition-related community events, and leading/participating in planning Transition Fairs. The next phase is CYSHNS working to improve its direct services with youth/families related to transition to adult health care, using an evidence-informed quality improvement approach.</p> <p>The Six Core Elements of Health Care Transition is an evidence-informed model for transitioning youth to adult health care providers that has been developed and tested in various clinical and health plan settings. They were developed by the Got Transition/Center for Health Care Transition Improvement, based on the joint clinical recommendations from the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), and American College of Physicians (ACP). References: Got Transition, "Side-By-Side Version, Six Core Elements of Health Care Transition 2.0"; AAP, AAFP, ACP, "Clinical Report – Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home", Pediatrics 2011;128:182-200; McPheeters M et al., "Transition Care for Children With Special Health Needs", Technical Brief No. 15. Agency for Healthcare Research and Quality (AHRQ) Publication No. 14-EHC027-EF, June 2014.</p>									

Form 10

Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 4.1 - Percent of Women, Infants, and Children (WIC) infants ever breastfed

2016-2020: NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active								
Goal:	Promote Breastfeeding in all WIC clinics statewide								
Definition:	<table border="1"> <tr> <td>Unit Type:</td><td>Percentage</td></tr> <tr> <td>Unit Number:</td><td>100</td></tr> <tr> <td>Numerator:</td><td>Unduplicated number of WIC infants ever breastfed by SFY</td></tr> <tr> <td>Denominator:</td><td>Unduplicated number of WIC infants by SFY</td></tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Unduplicated number of WIC infants ever breastfed by SFY	Denominator:	Unduplicated number of WIC infants by SFY
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Unduplicated number of WIC infants ever breastfed by SFY								
Denominator:	Unduplicated number of WIC infants by SFY								
Data Sources and Data Issues:	Hawaii WIC Program Data								
Significance:	<p>Breastfeeding is the normative standard for infant feeding and nutrition and can result in improved infant and maternal health outcomes. Given the indisputable short- and long-term advantages of breastfeeding, infant nutrition is considered a public health priority. The American Academy of Pediatrics (AAP) recommends that all infants be exclusively breastfed for about six months with continuation of breastfeeding for one year or longer. Breastfeeding is also encouraged and supported by other agencies such as the United States Department of Agriculture's (USDA) Food and Nutrition Service (FNS).</p> <p>However, as rewarding as breastfeeding can be, some women choose not to breastfeed and many women who start breastfeeding often stop when they are faced with challenges. With appropriate guidance and education, women can overcome these obstacles and continue breastfeeding for longer periods.</p> <p>WIC is the largest public breastfeeding promotion program in the state and nation, providing mothers with education and support as a core service. Moreover, promoting and/or facilitating community activities that reinforce breastfeeding may allow for more women across the state to have access to the support they need to initiate breastfeeding and continue doing so exclusively for at least 6 months.</p>								

2016-2020: ESM 13.2.3 - The number of organizations and individuals participating in State Oral Health Coalition meetings and activities

2016-2020: NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active		
Goal:	To improve the oral health of children.		
Definition:	Unit Type:	Count	
	Unit Number:	80	
	Numerator:	Not Applicable	
	Denominator:		
Data Sources and Data Issues:	Hawaii Children’s Action Network Roster for State Oral Health Coalition		
Significance:	<p>Cavities (also known as caries or tooth decay) are one of the most common chronic diseases of childhood in the United States. Untreated cavities can cause pain and infections that may lead to problems with eating, speaking, playing, and learning. Children who have poor oral health often miss more school and receive lower grades than children without disease.</p>		
	<p>The good news is that most tooth decay is preventable when children have access to evidence-based prevention strategies. To prevent tooth decay, the American Academy of Pediatrics recommends several strategies for enhancing the oral health of young children including: parent/family education on oral health (particularly eating nutritious foods and limiting sugars, and brushing teeth with a toothpaste containing fluoride); first preventive visit to a dentist within six months of the first tooth erupting and no later than age 1, with preventive check-ups thereafter; a series of topical fluoride applications to children’s teeth; and drinking fluoridated water.</p>		
	<p>With limited access for fluoridated water, a 2015 survey of Hawaii third graders documented some of the highest rates of decay in the U.S. To address this complex issue, a multi-faceted team and approach are needed which span across different settings and systems. Community collaboration and capacity, with representation across different public and private sectors, can help to address the complex issue of child oral health from multiple angles.</p>		

Form 11
Other State Data

State: Hawaii

The Form 11 data are available for review via the link below.

[Form 11 Data](#)

Form 12
MCH Data Access and Linkages

State: Hawaii

Annual Report Year 2020

Data Sources	Access				Linkages	
	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Annually	9		
2) Vital Records Death	Yes	Yes	Annually	9	Yes	
3) Medicaid	No	No	Never	NA	No	
4) WIC	Yes	No	Annually	6	No	
5) Newborn Bloodspot Screening	Yes	Yes	Quarterly	3	No	
6) Newborn Hearing Screening	Yes	Yes	Quarterly	3	No	
7) Hospital Discharge	No	No	Never	NA	No	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	24	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	1) Vital Records Birth
	Field Note: Access to Vital Records Birth data is through the VSS system at the Vital Statistics Office.
Data Source Name:	2) Vital Records Death
	Field Note: Access to Vital Records Death data is through the VSS system at the Vital Statistics Office.
Data Source Name:	3) Medicaid
	Field Note: Hawaii SSDI linkage activities are focused on the development of an All Payers Claim Database (APCD) which would include Medicaid, Medicare, and State Employee Union claims data. The project is a partnership between DOH, DHS, and the Insurance Commissioner. It is being managed by DHS through a contract with the University of Hawaii. The data is undergoing quality testing. The Data Analytics Group at DHS will analyze data requests. Several requests for analysis for Department of Health are on the list for analysis. There are no plans to release data directly to researchers at this time.
Data Source Name:	4) WIC
	Field Note: With the installation of a new data system, WIC no longer has direct access to its data. A private third-party vendor now collects, analyzes and reports data to the WIC program.
Data Source Name:	5) Newborn Bloodspot Screening
	Field Note: Newborn screening data was linked to vital statistics in the past, was suspended during the suspension on the linkage with birth records data. The linkage has restarted again in 2021.
Data Source Name:	7) Hospital Discharge
	Field Note: The Healthcare Association of Hawaii (HAH) is the new manager for all hospital data in the state. HAH is the nonprofit trade organization serving Hawaii's hospitals, skilled nursing facilities, assisted living facilities, home care companies, and hospices. The data is managed by a new subsidiary created in 2018, the Lailima Data Alliance. The Lailima Data Alliance has provided a portal for DOH users if summary results are needed. Record-level data is available for purchase. DOH established a new data governance committee which includes a representative from HAH. This committee approves and oversees/coordinates all hospital data requests.
Data Source Name:	8) PRAMS or PRAMS-like

Field Note:

In 2017, enforcement of a Hawaii Revised Statutes law related to data sharing policies for the Hawaii vital records office severely limited and stopped data sharing from the Hawaii Vital Records office for PRAMS. During the 2018 legislative session, FHSD worked with the Office of Health Status Monitoring to pass legislation to allow department of health employees access to vital records data. Since July 2018 DOH employees may request and receive individual record level vital statistics data after approval from the Department of Health (DOH) Institutional Review Committee.

The restricted access to vital statistic data resulted in temporary suspension of Hawaii PRAMS program data collection which relies on birth records to draw its monthly sample. With the law change, Hawaii PRAMS data collection resumed in December 2018. In February 2019, the Institution Research Committee and the Director of Health approved FHSD's ongoing access to birth, death, and fetal death records.